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SEVENTY BIRTH CONTROL CLINICS: A survey and Analysis, Including the General Effects of Control on Size and Quality of Population, Baltimore, The Williams & Wilkins Company, 1930

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SEVENTY
BIRTH CONTROL CLINICS

MEDICAL ASPECTS OF HUMAN FERTILITY
SERIES ISSUED BY THE
NATIONAL COMMITTEE ON MATERNAL HEALTH

SEVENTY BIRTH CONTROL CLINICS

A SURVEY AND ANALYSIS INCLUDING THE GENERAL EFFECTS OF CONTROL ON SIZE AND QUALITY OF POPULATION

by

CAROLINE HADLEY ROBINSON

foreword by

ROBERT LATOU DICKINSON

BALTIMORE
THE WILLIAMS & WILKINS COMPANY
1930

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FOREWORD

EVERY new endeavor to better public health passes through a difficult early stage. Control of contagious disease, control of pain in labor, control of infection in operation or delivery; vaccination, chloroform or antisepsis—all are advances that have been made in the face of timidity and prejudice, not only from many individuals, but also on the part of organizations representing the learned professions.

Control of conception presents no exception. In this department of preventive medicine, however, the study of the matter and of the beginnings of service rendered to the poor are subject to handicaps peculiar to themselves. The transmission of information that is essential is hampered by law and custom and the custom house; opposition is dogmatic and emotional; the experience of any one individual is limited. The more need, therefore, of careful collection of data and open minded analysis of whatever tests of the application of this knowledge have been made.

Hence this book.

The physician and the sociologist will welcome a survey of methods of getting evidence and a chance to evaluate some of the evidence. Five years of follow-up outweigh fifty years of fumbling.

The question is no minor problem. One in four of our adult population has a right to knowledge needed at short intervals for nearly half a lifetime. It is always a question in any such study what fullness of detail is requisite in order to carry weight. This differs with the status of the

activity or issue. With beginnings and in experimental stages an elaboration is relevant and useful which becomes mere clutter and matter-of-course in a stage where technique and methodology have been accepted. In the particular section of preventive medicine with which this book deals we are just beginning to emerge from the stage of "my own opinion."

The author, Mrs. Louis N. Robinson, wife of the well known criminologist, is primarily a student of economics, with a particular interest in the problems of population. A graduate of Swarthmore, she took her M.A. in economics at Columbia. The material for this book was gathered in connection with her preparation for a doctorate.

Mrs. Robinson is the better qualified to support her convictions in that she has shown a life-long interest in collecting facts. Moreover, she can the better maintain a perspective in that she has not associated herself with the radical wing of the birth control movement. Her statistical bent and her theories have been tempered—but not institutionalized—by the institution of the family. A happy and successful home life with her six children, a personal history comprising much study and travel, and her extended observations on birth control clinics, entitle her to a hearing. To be a Quaker, and a *Philadelphia* Quaker, should in itself involve a certain shrewd sense and tolerant sympathy and a *flair* for sane social service —if the late war is any gauge of the various groups that make up this confused world.

The survey embodied in this volume and the deductions therefrom were made not alone through study of clinic reports or correspondence, but in large part through per-

sonal inspections. Thus in Los Angeles, San Antonio, Chicago, Newark and New York; London, Liverpool and Yorkshire; the Hague, Amsterdam, Berlin and Vienna, clinics were visited by the author, or else by a representative of the author or of the Committee on Maternal Health, or by the Secretary of this Committee. Certain clinics have been repeatedly visited, and some by three or more observers.

Moreover, painstaking and detailed assistance has been rendered, in three separate portions of this undertaking, by A. M. Carr-Saunders, Professor of Social Sciences, University of Liverpool; by Dr. Robert M. Woodbury, Associate Editor, Social Science Abstracts, Columbia University, New York, formerly of the Children's Bureau; and by Dr. Paul Popenoe, of the Human Betterment Foundation, Pasadena, writer on eugenics and sterilization.

The National Committee on Maternal Health heartily welcomed this manuscript as most opportune, and in view of the ceaseless iteration of requests for the very kind of information the author has gathered, we have been glad to issue it as the first of our series of publications on the *Medical Aspects of Human Fertility*. We acknowledge the privilege of including certain observations and additions based on an experience of six years in initiating and fostering clinics, without, however, accepting responsibility for the author's opinions or statements of policy. The material has been edited throughout, but with care to avoid weakening its initial vigor or personal point of view, particularly in the second part. The major editorial responsibility has fallen upon the Executive Secretary of the Committee, Dr. Louise Stevens Bryant, assisted by Mrs. Mary Louise Inman, Editorial Secretary.

The movement that started with the purpose of safeguarding the health of mothers and spacing children properly has inadvertently found itself extensively occupied in a new and important field—the regular health examination of women, which discovers a multitude of unsuspected disorders requiring attention. To my thinking, the movement is bound to extend so as to cover the whole area of conjugal and premarital advice as soon as Marriage Consultation Centers develop to the point of calling for the services of priest and physician, psychologist and social worker to round out this socialized department of preventive medicine.

ROBERT LATOU DICKINSON.

May 14, 1930.

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INTRODUCTION AND SUMMARY

ENTHUSIASTS in many lands are calling for the establishment of birth control clinics. It is important therefore that information be accessible which will enable socially minded citizens, and particularly members of the learned professions, to form intelligent opinions on this intricate problem.

This survey gives details concerning seventy organized centers—which may properly be called clinics—for birth control instruction, and lists more than two hundred and fifty others, about half of them by name. It is intended as a guide to the nature, extent, and status of this world-wide movement, insofar as these may be objectively determined by descriptions of leaders and workers, their policies, procedures, and experiences, the numbers of people reached, the expenses entailed, and the character and trend of public and professional opinion as reflected in laws and letters. The scientific character of the movement is also to be gauged by the data assembled and the analysis given them by students of the subject.

This survey is intended to be a practical handbook for those engaged in one branch of medical philanthropy. It elaborates the social rather than the medical aspects of the subject, although such professional problems as medical personnel and training and equipment and "medical indications" are fully considered in Chapter VI which was written by Dr. Dickinson and Dr. Bryant. What it is in no way intended to be is an answer to clamor on the part of the public for a pamphlet giving instruction to all

and sundry on means to avoid conception. Not only do our laws prevent all interstate carriage of such information, but for many couples their individual peculiarities should be met by selection of the means adapted to their needs, and this is a selection best undertaken by physicians because in any method effectiveness largely depends on attention to details.

The first six chapters of the book have to do with the history and practice of organized birth control. The final chapters turn to more fundamental questions, among others those arising from any supposed effects of contraception on quantity and quality of population.

In the first seven chapters, the author has been highly pleased and gratified to receive detailed confirmation and correction from the Committee on Maternal Health, a body which because of its established medical connections is, more than any other, competent to criticize.

Readers with no professional interest in special phases of birth control will do well to read Chapters I and II, and a little way in Chapter III. After that, the following may be recommended: Chapter IV, taking up the topic of "race suicide;" a glance at Chapter V on founding clinics; and careful attention to Chapters VII and X, which summarize arguments *pro* and *con*.

SECTIONS OF INTEREST TO SPECIALISTS

On the subjects of prenatal mortality (Chapter III) and differential birth-rates (Chapter IX), the specialist will find critical paragraphs covering a great deal of the recent research, which may repay his attention. Also in Chapter VIII some of the trends of thought concerning popu-

lation are summarized, which have occupied European statisticians, particularly the British, since 1906.

REFERENCES

In each chapter many statements are supported by references to titles in the Bibliography at the end of the volume, indicated by an initial and a numeral in parenthesis. A conscious effort was made in each chapter to include references to essential authors on that particular subject, without attempting an exhaustive bibliography on birth control. The student desiring further titles is referred to A. B. Wolfe's bibliography, the most recent dealing with population science in general (W-8); to the classic collection by Theodore Schroeder antedating clinics (S-8); and to the one by Julia E. Johnsen (J-3.)

SUMMARY OF FACTUAL FINDINGS

A birth control clinic may be defined as an out-patient service where, in the interests of the individual or of the community, physicians prescribe means for postponing or preventing conception, but refer to a hospital those patients whose condition might possibly there be found to justify a legal abortion, or permanent sterilization without unsexing. Birth control is not and cannot be prescribed even a few days after conception has occurred. Essentially a birth control clinic exists to provide the masses with the means of conscious control now exercised by the more favored classes. The positive aspect of birth control is increasingly recognized in the clinics by the provision for care of *involuntary* sterility.

The seventy clinics described in detail fall into two

general classes: half are concerned exclusively with giving birth control advice, and half include this with other forms of medical or social care.

Of the seventy clinics established in ten years the first was in 1919, but more than half came into existence between 1926 and 1929. More than 70,000 patients have been treated, and case records kept. Some of the records may ultimately yield important data for social, medical, or psychological science.

The whole development is scarcely distinguishable in any way from other medical charities of the modern welfare movement, except that some well-to-do women are found among the hosts of poor clients, especially in the pioneer centers.

Medical women or men examine all patients at all but three clinics. First visits commonly require twenty to thirty minutes apiece, but a few inept women may need an hour or more.

There is a striking uniformity of method in treatment and instruction. The prescription appears to fail with about four to twenty per cent of all patients, including the careless and stupid with those who appear to use it correctly. The patients do better about persisting in the line of action proposed to them than is customary at many dispensaries giving more usual types of medical care.

The vast majority of patients were already attempting, before coming to the clinic, to limit their families—often by harmful methods.

Religious groups whose leaders object to contraception are represented among American patients in about the same proportion as in the general population.

The clinics are universally engaged in collecting pre-

natal and other mortality statistics, though these are unfortunately of scant value as at present recorded.

All take some patients free, and in many the service is practically free to the poor. Some centers do their work at a very low cost, and reach large numbers, while in others costs are high and an insufficient number of the needy are served, partly because of the prohibitions and inhibitions against public advertisement of these resources.

Numbers of obscure clinics reach a lower class clientele than do the three famous pioneer propagandist centers in London, New York and Chicago; some reach the very lowest. In eighteen instances we have figures on occupation or income to guide our judgment. In at least ten of the clinics, unskilled laborers are present in excess of their proportion in the general population; in the others they are probably at least normal. This is in accord with what would appear eugenically desirable. Careful examination of the fears of the eugenicists concerning the clinics and the differential birth-rate seems to reveal at least four weak links in their theoretical and statistical argument, which nullify it and cause these fears to seem unjustified.

Taking the movement as a whole, many steps have been and can yet be taken to make it more eugenic.

At least two nations and five local governments in the United States and six in Europe officially promote birth control directly or indirectly. At least twenty-three additional nations are neutral besides many of our states—twenty-three certainly, although forty is probably nearer the correct number of neutral nations.

CONCLUSIONS OF A MORE GENERAL NATURE

Social scientists and social workers, except Catholics, are nearly unanimous in favoring birth control; part of the medical press and many medical leaders are also very favorable. It is not easy to find outspoken, unqualified enemies in any group of people anywhere except among Imperialists, as in Italy, and among the celibate clergy and their followers. But the latter wield great influence because strongly entrenched politically, especially in cities.

Opinion thus favors birth control by uniting the evidence from four sciences. *Physicians* perceive the tremendous prevalence of abortion and prostitution; *biologists* recognize that the birth-rate of human beings is nearly everywhere much less than their animal constitution plus their controlled environment would make natural; *sociologists* list the elaborate restrictive mating customs of savages and of all men, which reduce their fertility; and *psychologists*, noting the irrepressible urgency of the sex instinct, realize how overwhelming must be the social necessities that keep it from unbounded expression.

We are coming to realize that *voluntary* limitation of the family is an essential part of the economic structure of nearly every age and clime, and that we must choose between measures—in particular the old forms of limitation by abortion and infanticide, by celibacy or postponement of marriage (with prostitution), and the newer discoveries of social medicine.

A corollary to the fact of nearly universal voluntary limitation in every place and time, is this: If mankind has always exercised only a fraction of its possible fertility,

then the recent inventions and practices of birth control are more of a *new means* to, than a *cause* of, reduced populations. Four races and three large groups are offered in evidence on this corollary; also the writings of many statisticians and other scientists.

The birth control movement is essentially a medical innovation destined, like the invention of anesthetics, to obviate certain extensive types of physical and mental suffering. That it will have very much effect on quality of population or on quantity does not at present appear. Poverty will probably be definitely and greatly affected in certain limited ways. The "hands" will not be fewer, nor able on account of their scarcity to demand more wages. But they will be somewhat healthier workmen.

THE MENTAL APPROACH TO BIRTH CONTROL

Birth control centers have, as a rule, been started by persons who are humane in their outlook and of wide experience among the poor. For example, Margaret Sanger was a registered nurse working in the slums. Dr. Helene Stöcker in Berlin had long labored for Germany's illegitimate children and their mothers. The elder Drysdales were British medical people laboring in this then unpopular cause for human good as they saw it. Dr. Aletta Jacobs and Dr. Rutgers (Holland) and Dr. Riese (Frankfurt) were physicians working among the poor. In California the sponsors have been almost wholly compassionate physicians; in Chicago, they included a daughter of the founder of organized charity there. Their immediate purpose was to reduce misery among families where the mother was continually becoming pregnant without

hope of being able to bring up her offspring properly—or, in some cases, of bringing them even as far as a healthy birth. This was the laudable impulse behind the movement, however mistaken it may have appeared to opponents on religious and other deep grounds.

The opponents include certain theologians, many of the imperialists in every country, and, until recently, the eugenicists. The latter are without emotional bias so far as is observable. The imperialists are interested only in the effect of birth control on quantity of population, each wishing his country to become ever more populous and powerful. If they become convinced that birth control can have but slight effect on total quantity of population because quantity is a phenomenon governed by many and deep causes, their present opposition may be expected to cease. But the old-fashioned religious people will not be reconciled, because their theological objections to birth control are founded not so much in concern for quality or quantity of population as in a deep revolt against the aspiring modern notion that the scientific mind, and not a god outside us, is master of our fates. And birth control centers harbor a particular specimen of this modern notion; i.e., that it is not God, but a person's own carelessness, that burdens him with more children than he is able to maintain.

The present writer approached this subject with the hope that birth control was to prove the long-sought solution of the problem of poverty. That hope is not now so strong as it was. Also, it was a surprise to find a certain accord everywhere (outside Catholic circles) upon birth control, and the author herself in agreement with it! In

spite of much acrimonious discussion, some persons writing savagely and others enthusiastically on the subject, there is a good deal of agreement upon fundamentals. As Professor Kelsey has said, it appears that "the conflict of ideals is not as divergent as extremists on either side believe." (K-2)

Most American and European opinion may be said to revolve pretty closely about the following statement: *the use of contraceptives is right when practiced by married persons for adequate reasons.* The adequacy of the reasons is naturally, in a democracy, left to each couple to decide, and in practice this is what actually takes place. (See Chapter VII).

In this matter charity is desirable. Particularly, the twenty-five per cent of upper class married couples who have, according to Dr. Davis' figures, an average of only 1.31 children *without* practicing birth control, must not pass judgment upon the seventy-five per cent who have more children in spite of practicing it. (D-5, p. 16) In the present stage of science the twenty-five per cent are not justified in calling the seventy-five per cent "animal in their habits," as they sometimes do, for we simply do not know whether the two groups differ in their habits. The fertile seventy-five per cent may merely be more *animal* in the sense of being more healthy.

Birth control, always a delicate subject, and in its concrete details perhaps unesthetic, is not to be discussed at all times any more than last illnesses, funeral rites or undertaking. Some one has said that these matters are conjoined: not until death has visited the house can there really be room for a new member in the world, or often in

the immediate family budget. But even considered in the same category as funereal matters, birth control is a far more important subject. Races dispose of their dead in all kinds of ways—for instance, by allowing the birds to pick the bones. It is but custom. No profound moral or esthetic damage is wrought. But the ancient habits of limiting the family by methods far more distressing than modern contraception are very damaging. It is time that we changed our laws so as to adopt superior methods, and thereafter we may drop the subject as a matter of discussion, except in medical circles.

PART ONE

SURVEY OF BIRTH CONTROL CLINICS

I. ORGANIZATION, STAFFS AND STATISTICS FOR SEVENTY CLINICS

Location, Staffs and Organization—English Clinics—New York and Eastern Seaboard—Illinois and Mid-United States—California—Germany and Austria—Personalities in Clinic Building.

II. THE CASE PROCEDURE

Eligibility—Case History Sheets—Specialized Lines of Inquiry—Thoroughness of Teaching—Is Any One Unteachable?—Sterilization as a Last Resort—The Follow-up Work—Supply of Materials—Service by Mail.

III. SCIENTIFIC DATA OBTAINED AND SUGGESTIONS FOR HANDLING IT

Religion of Patients—Limitation Methods Formerly Used by Clients—Results, Successful and Unsuccessful—Importance of Cases Not Reported—Maximum Failure Possible at New York Clinic—Gross versus Net Fertility—Good Fertility but Not Mortality Rates—Prenatal Data—Data on Children's Deaths—Correct Method of Showing Effect of Repeated Pregnancies—Previous Studies—Suggestions for Handling These Data.

IV. ORGANIZED BIRTH CONTROL BECOMING EUGENIC

Summary of the Statistics—Summary of Other Evidence—Excess of Unskilled and Upper Class Clients—Unusual Social Status at the Three Pioneer Clinics—The Skilled Artisans—Reaching the Poor the Main Object—How Increase Service to the Less Fit?—Case Work the Ultimate Means of Reaching the Less Fit—Propagandists and the Birth Rate Among the Fit—"Suicide" Among the Privileged Classes—Age and Infertility—Summary.

V. PRESENT PRACTICE IN FOUNDING AND FINANCING

The Need for Money greater than Legal Difficulties—How Certain Clinics are Financed—Cost per Case—Fees, Charges for Materials, Approximate Costs—Raising Money for Birth Control—Obtaining Clients—Source of German Clients—Source of New York Hospital Clients—Crucial Relation of Finance to Clients.

VI. PLANNING CLINICS FOR PRESENT AND FUTURE NEEDS

General Administration—Office Plans—Attracting Doctors to Birth Control Clinic Work—Payment for the Doctor—Former Skill Newly in Demand—Clinical History Forms—Medical Indications for Contraceptive Care—The Enlarging Field—Conjugal Hygiene.

CHAPTER I

ORGANIZATION, STAFFS, AND STATISTICS OF SEVENTY CLINICS

Clinic service for birth control is now more widespread than has yet been realized. While collecting details on seventy centers of this kind in Europe and the United States, which had treated over 70,000 patients, some two hundred and fifty other centers were heard of for which statistics were not available. This probably includes most of the organizations throughout the world, though as new centers are being opened annually the list cannot be kept complete. There are also certain mail services which are discussed in the next chapter. The clinics surveyed number about a dozen in each of the following places: Germany, Austria, England, and New York City, the remainder being in other parts of the United States.

The seventy clinics are listed in Table I, giving name, location, auspices, year founded, hours open, and patients treated. Appendix C lists, without details, other centers on which we are not informed or which were reported too late for us to include.

Unfounded Claims. The student of the subject is often misled. One is solemnly assured by printed page or word of mouth: "There is a birth control clinic in such-and-such a city; it was opened this month." On investigation one finds that it never quite succeeded in opening. Hence the necessity for the accompanying table, in the

interests of accuracy. It enables one to judge by the years of operation, by the hours when open, and by the number of patients treated, concerning the solidity of each institution and the scope of the whole movement.

Types of Management. The clinics named in the table are all staffed by members of the medical profession in good standing, with the exception of No. 13, which is run by a social worker, and No. 39, by a registered nurse. All but the latter keep case records. They take chiefly charity cases and are run without profit or personal gain, except in the case of Nos. 15 and 63, where the service is composed of the specialized practice of individual physicians in their private offices.

Types of Patients Eligible. The majority of the seventy clinics give patients advice for social and economic reasons, or simply on request, as well as for medical reasons. Those starred in Table I give it *for medical reasons only*—to save life or safeguard health. But the interpretation of "life" and "health" varies: one physician in these starred clinics will prescribe contraception *only* if another birth means *immediate death* to the mother; at the other extreme is one who will prescribe if the child to come *might* suffer from malnutrition, mental defect, or other predictable malady. But different physicians, especially in different states with varying laws on birth control, will view differently the likelihood of ensuing misfortune. For instance, one doctor will fear a severe mental twist that may result if the child is likely to grow up disliked by its parents, but another will consider nothing less than the certainty that two feebleminded parents will have feebleminded children. Also, the same physician will sometimes be governed by one or other policy

according to the circumstances of the particular case. The Committee on Maternal Health includes a group of eminent physicians at work trying to bring some order and sense of proportion into this procedure, as well as into the similar chaos that exists regarding the medical indications for sterilization and therapeutic interruption of pregnancy.[1] Rules are lacking. Meanwhile the situation is that a woman seeking contraceptive advice can scarcely know beforehand whether she will be accepted or refused at one of these starred clinics.

Table I includes only the clinics studied in detail. The German clinics lead, not only because some of them are public institutions but because the facts given now appear for the first time in English. They were especially gathered for, and in coöperation with, the author by the Bund für Mutterschutz. (N-4) Clinics operating under the same auspices or in coöperation with the same committee are grouped together, but this has not hindered a general grouping by location. Chronological sequence is not strictly followed.

Two General Classes of Clinics. The centers in Table I happen to divide equally into two general classes. First, there are the special stations having nothing to do with any kind of philanthropy except birth control; for instance, most of the English and about a third of the American. The Austrian and a few additional American centers are devoted to birth control exclusively but are located in settlement houses, offices for government insurance or other organizations.

[1] See Chapter VI. In England the latest volume (M-15) of the rather conservative Council of Public Morals formulates a plan for guidance on this question.

Coming now to the second general class of clinics, we find something quite different—a staff organized in part, or sometimes for all except one session weekly, for medical or charitable work other than birth control. These include all the German centers which deal with all sorts of sexual and marital difficulties from legal to psychological; the services in gynecological and health center clinics, comprising about two thirds of the American centers; and finally those two very important centers where birth control is an integral part of a general welfare program for the needy classes; namely, the Pioneer Health Center in London and the Jewish family agency in Chicago. (Nos. 38 and 55.) It should also be noted that in California the services, both special and out-patient, are so closely tied in with the organized charities that they reach the poorer classes almost as exclusively as the Chicago Jewish and the London No. 38. In Moscow No. 25 does its contraception as part of a complete medical program for the whole industrial population (B-30). Hence, as there is so little selection, its eugenic effect must be less than in the last six mentioned.

LOCATION, STAFFS AND ORGANIZATION

Most English and American clinics, and nearly one third of the German, are staffed by women doctors.

Most clinics have locations convenient to the poor.

Only Walworth, North Kensington, and New York No. 40 (Clinical Research Bureau) and some of the hospitals are working on a scale to accommodate a large number of clients simultaneously.

We will now consider them one by one, beginning with

the English. The English clinics have been more intimately studied by Mr. Norman E. Himes, while on a fellowship from the Social Science Research Council. (H-3) (H-4) Our account of the Germans is very sketchy, but it is the only thing we know of on the subject except two German pamphlets (N-4) (B-4) and one book. (H-6) It is the American field we have striven most particularly to picture.

ENGLISH CLINICS

The first British clinic was the "Mother's Clinic" (No. 26 in Table I) opened in 1921 by Marie Carmichael Stopes, Ph.D. (Munich), D.Sc. (London), F.L.S., etc. It occupies a small dwelling in a modest residence street of London. The daily sessions are conducted by a midwife (a trained nurse with a special license) and two clerks, and a woman doctor is in attendance at one session a week to see all "difficult" cases referred by the nurse, who constitute about one fifth of all patients. It has also, of course, the general supervision of Dr. Stopes, formerly a university lecturer in biology.

Twelve of the English clinics operate under the general direction and sponsorship of the Society for the Provision of Birth Control Clinics, organized in 1923, and having headquarters at Walworth Center which had been opened in 1921. Ten of these are listed in Table I (Nos. 27–36). The Society for the Provision of Birth Control Clinics is attempting to establish in its separate units modern standards of out-patient service, in particular, sole medical control over medical matters. Two or more physicians divide the work between them at each center, receiving an

TABLE I

Seventy Clinics and Centers for Birth Control Service

Location, date founded, auspices, hours operated weekly, number of patients treated annually and total received at time of report. Sources: official reports and letters.

Clinic		(1)	(2)	(3)	(4)	(5)	(6)
			Year			New Patients (a)	
Serial Number	Name and Location	Main Auspices or Support	Founded	This Report	Clinic Hours per Week	Per Year	Total at Date of This Report
	GERMANY Ehe- und Sexualberatung-stellen (Stations for Marriage and Sex Advice)						
	A. Municipal Stations (Amtlichen)						
1	a. Dresden, Sternplatz Ortskrankenkasse	City	1923	1928	3	(572)	(1,000)
2	b. Berlin, 113, Greifenhagener Strasse, 58	City	1926	1928	4	22	(724)
3	c. Berlin-Wedding, Berlin N., Wattstrasse, 16	City	1927	1928	1	158	223
4	d. Berlin-Neukölln, Erckstrasse, 27	City	1927	1928	4	22+	22+

5	e. Kiel, Gesundheitsamt im Rathaus	City	1925	1927	2	—	5
6	Institut für Sexualwissenschaft, Berlin, N. W., Beethovenstrasse 3	Trust Funds	1919	1928	3+	450 (about)	4,500+
	B. Stations of Bund für Mutterschutz						
7	a. Berlin Friedrichshain, Schillingsbrücke, 2	Bund and City	1926	1928	2	166	(441)
8	b. Berlin Kreuzberg, Gesundheitshaus, am Urban, 10	Bund and City	1926	1928	2	146	(850)
9	c. Frankfurt a. M. Bethmanstrasse 19, Z. 41	Bund	1924	1928	4	360	(750)
10	d. Hamburg, Kaiser Wilhelmstrasse, 93	Bund	1924	1928	1	19	(1,023)
11	e. Hamburg, Bismarckstrasse, 79	Bund	1924	1928	1	100+	508
12	f. Mannheim, Gebaüde des Jugendamts, R 5, 1	Bund	1924	1928	1	8	(288)
13	g. Breslau, I, Garvestrasse, 29	Bund	1926	1928	2	25	(315)

TABLE I—*Continued*

Clinic		(1)	(2)	(3)	(4)	(5)	(6)
			Year			New Patients (a)	
Serial Number	Name and Location	Main Auspices or Support	Founded	This Report	Clinic Hours per Week	Per Year	Total at Date of This Report
	C. Under Arbeiter-Samariter-Kolonne						
14	a. Chemnitz i. Sa, Armenstrasse 11	Soc. Org.	1927	1928	3	51	(129)
15	Ehe- und Sexualberatungstelle von Dr. med. Dehmel, Berlin, W. 35, Steglitzer Strasse, 57	Private	1926	1928	6	47 (about)	93 (about)
16	Eheberatungstelle, Berlin-Reinickendorf, Hauptstrasse, 46	Committee	1928	1929	4	(300)	(300)
	AUSTRIA						
	D. Frauenschutzberatungsstellen (Ferch)		1922–1926	1928	—	1,280(b) (about)	6,440(b) (about)
17	a. Vienna, VI, Königseegasse 10, Tür 2	Soc. Org.	1922	—	—	—	—
18	b. Vienna II, Karmelitergasse, 9	Soc. Org.		—	—	—	—

19	c. Vienna VIII, Alserstrasse 23	Soc. Org.		—	—	—	—
20	d. Vienna IX, Währingerstrasse, 43, Tür 23	Soc. Org.		—	—	—	—
21	e. Vienna X, Leebgasse, 17b	Soc. Org.		—	—	—	—
22	f. Vienna XIII, Eduard Kleingasse 2, Part.	Soc. Org.		—	—	—	—
23	g. Vienna XX, Brigittaplatz, 10, Part.	Soc. Org.		—	—	—	—
24	h. Vienna XXI, Pitkagasse, Ecke Scheifgasse Schlingerhof	Soc. Org.		—	—	—	—
	RUSSIA						
25	Moscow: Medical Unit in charge of workers and families in 28 factories	City	Before 1927	1927	—	1,200+(c)	2,500+(c)
	GREAT BRITAIN						
26	The Mothers' Clinic (Stopes) 108 Whitfield St., Tottenham Court Road, London, W. 1	Private	1921	1926	40	1,500	8,000
	E. Society for the Provision of Birth Control Clinics	Soc. Org.	1921	1929	—	3,881	20,929
27	a. Walworth Women's Welfare Centre, 153a, East St. Walworth Rd., London, S. E. 17	Soc. Org.	1921	1929	$4\frac{1}{2}$	1,194	11,648

TABLE I—*Continued*

Clinic		(1)	(2)	(3)	(4)	(5)	(6)
			Year			New Patients (a)	
Serial Number	Name and Location	Main Auspices or Support	Founded	This Report	Clinic Hours per Week	Per Year	Total at Date of This Report
28	b. North Kensington Women's Welfare Centre, 12, Telford Road, Notting Hill, London, W. 10	Soc. Org.	1924	1929	2½	372	1,813
29	c. Wolverhampton Women's Welfare Centre, 62, Heath Street, Heath Town, Wolverhampton, London	Soc. Org.	1925	1929	2	193	1,187
30	d. East London Women's Welfare Centre, 6, Burdett Road, Stepney, London E. 3	Soc. Org.	1926	1929	3	468	1,549
31	e. Cambridge Women's Welfare Assoc., Fitzroy Hall, Wellington St., Cambridge	Soc. Org.	1925	1929	3½	138	627
32	f. Manchester, Salford and District Mothers' Clinic, 161, Green Gate, Salford	Soc. Org.	1926	1929	1	261	1,173

33	g. Glasgow Women's Welfare and Advisory Clinic, 51, Old Govan Rd., Glasgow, Scotland	Soc. Org.	1926	1929	2+	187	706
34	h. Oxford Family Welfare Assoc., 4, King St., Jericho, Oxford	Soc. Org.	1926	1929	2½	38	158
35	i. Birmingham Women's Welfare Centre, 9, Castle St., High St., Birmingham	Soc. Org.	1927	1929	3	607	1,379
36	j. Aberdeen Women's Welfare Centre, 4, Gerrard St., Gallowgate, Aberdeen, Scotland	Soc. Org.	1926	1929	2	142	365
37	(Liverpool) Mothers' Welfare Clinic, 23, Clarence St., Liverpool	Soc. Org.	1926	1928	—	100+	234
38	Pioneer Health Centre, 142, Queen's Road, Peckham, London, S. E. 15	Pub. Health	1927	1928	—	1+	1+
39	Mrs. Waddington's Clinics, Yorkshire, Boathouse Lane, Mirfield (Branch at Goole, 57, Dunhill Rd.)	Private	1924	1927	4	—	265

TABLE I—*Continued*

Clinic		(1)	(2)	(3)	(4)	(5)	(6)
			Year			New Patients (a)	
Serial Number	Name and Location	Main Auspices or Support	Founded	This Report	Clinic Hours per Week	Per Year	Total at Date of This Report
	UNITED STATES						
	NEW YORK						
40	*Birth Control Clinical Research Bureau, 17 West 16th St., New York City	Sanger	1923	1929	22(d)	4,300	15,200
	F. Committee on Maternal Health (Hospital services in gynecological departments						
41	*a. New York Infirmary for Women and Children, 321 East 15th St., N. Y. C.	Hospital and Com.	1923	1928	2	—	101+
42	*b. Mt. Sinai Hospital, Madison Ave. and 100th St., N. Y. C.	Hospital and Com.	1925	1928	2	—	213+
43	*c. Woman's Hospital for the State of New York, 141 West 109 St., N. Y. C.	Hospital	1924	1928	1	—	36+

44	*d. Brooklyn Hospital, DeKalb Ave., Brooklyn	Hospital	1923	1927	(e)	—	6+
45	*e. Vanderbilt Clinic (Sloan and Presbyterian Hospitals) Medical Center, 168 St. and Broadway, N. Y. C.	Hospital	1926	1928	3	—	92+
46	*f. New York Nursery and Child's, 161 West 61st St., N. Y. C.	Hospital	1926	1928	1	—	22+
47	*g. Lenox Hill Hospital, Park Ave. and 76th St.	Hospital	1926	1929	2	—	62+
48	*h. Jewish Hospital of Brooklyn, Classon and St. Marks Ave.	Hospital	1926	1928	—	—	6+
	ILLINOIS *G. Illinois Birth Control League*		1924	1929	20	1,900 (f) (about)	5,376 (f)
49	a. Medical Center No. 1, 203 N. Wabash Ave., Chicago	Soc. Org.	1924	—	6 (d)	—	—
50	b. Medical Center No. 2, 1347 N. Lincoln St., Chicago	Soc. Org.	1925	—	6	—	—

TABLE I—*Continued*

Clinic		(1)	(2)	(3)	(4)	(5)	(6)
			Year			New Patients (a)	
Serial Number	Name and Location	Main Auspices or Support	Founded	This Report	Clinic Hours per Week	Per Year	Total at Date of This Report
51	c. Medical Center No. 3, Henry Booth Settlement House, 701 W. 14th St., Chicago	Soc. Org.	1925	—	2	—	—
52	d. Medical Center No. 4, House of Social Service, 3201 S. Wabash Ave., Chicago	Soc. Org.	1926	—	2	—	—
53	e. Medical Center No. 5, Jewish People's Institute, 1258 W. Taylor St., Chicago	Soc. Org.	1927	—	2	—	—
54	f. Medical Center No. 6, Mary Crane Nursery, Hull House, 818 Gilpin Place, Chicago	Soc. Org.	1927	—	2	—	—
55	Jewish Social Service Bureau, 18 Selvin St., Chicago, Ill.	Fam. Ag.	1924	1926	(g)	—	103

56	*Mandel Clinic of Michael Reese Hospital Dispensary, 29th St., and Ellis Ave., Chicago, Ill.	Hospital	1927	1929	2.5	50+	102
	CALIFORNIA						
57	Los Angeles Mothers Clinic Assoc., 646 Southwest Bldg., 130 South Broadway, Los Angeles, Cal.	Soc. Org.	1925	1929	(h)	1,027	3,800
58	*Los Angeles County Health Dept. (Nine centers)	County Funds	1927	1929	26	250	563
59	*Pasadena General Hospital Disp., Mothers' Guidance Clinic, 38 Congress St., Pasadena, Cal.	Hospital	1927	1929	—	—	132
60	Alameda County Public Health Center, Services in 2 gynec. clinics (Alameda and Hayward 1929)	County Funds	1925	1928	—	—	—
61	Oakland Mother's Health Clinic, Alameda County Birth Control League, 5720 Genoa St.	Soc. Org.	1929	1929	—	291+	291

TABLE I—*Concluded*

Serial Number	Clinic: Name and Location	(1) Main Auspices or Support	(2) Year Founded	(3) Year This Report	(4) Clinic Hours per Week	(5) New Patients (a) Per Year	(6) New Patients (a) Total at Date of This Report
62	San Francisco Maternal Health Clinic, Children's Health Center of American Association of University Women, 526 Oak Street	Com.	1929	1929	4	175+	175
	OTHER STATES						
63	(Texas) Private Clinic, San Antonio	Ind. M. D.	1926	1927	(i)	(i)	10
64	(Michigan) Detroit Mother's Clinic for Family Regulation, 1601 Blaine Avenue	Soc. Org.	1927	1929	8	300	600
65	*(Maryland) Bureau of Contraceptive Advice, 1028 North Broadway, Baltimore, Md.	Com.	1927	1929	9(h)	183	415

66	*(Ohio) Maternal Health Clinic, 311 Osborn Bldg., Cleveland	Soc. Org.	1928	1929	4	—	367
67	*(Ohio) Cincinnati General Hosp., Maternal Health Com. Clinic	Acad. Med. City Hosp.	1929	1929	2+	—	17+
68	*(New Jersey) Maternal Health Center, 47 New St., Newark, N. J.	Com.	1928	1929	12	215	215
69	*Colorado General Hospital, Gynecological Clinic, Denver, Colo.	Hospital	1928	1929	—	250+	500+
70	*(Georgia) Grady Hospital, Atlanta, Ga.	Hospital	1929	1929	—	1	1
Total.....			1919–1929			18,197	71,845

* Advice for health reasons only.

(a) Figures in parenthesis not included in total because not exact owing to non-separation of birth control service from others in records. Other figures are from report in year noted. Annual figures indicate rate at latest year reported usually, or for months since founding when clinic open less than year.

(b) Figures for the eight centers kept together. 320 patients were received in first months of 1927.

(c) 1200 in single month of October 1927 (B-30).

(d) Central office open continuously. Hours weekly refer to doctors presence.

(e) No regular clinic hours—incidental service as needed, no separate records kept.

(f) Figures not kept separately for branches.

(g) Office opened continuously for appointments arranged as needed with doctor.

(h) Office opened continuously for appointments, 2 or more sessions weekly with doctor.

(i) Private physician receives cases at any office hour, 18 weekly.

honorarium; nurses, who assist the doctors and give the detailed instruction to the women, are sometimes paid and sometimes volunteer. Each clinic has an active committee in charge, one member of which (sometimes the secretary) acts as a volunteer lay superintendent, while others assist her with clerical work or interviews.

English women of leisure apparently take their philanthropies much more seriously than women of other nations, and these "honorary" superintendents are quite apt to be at the clinic most of their time, really attending to the details of administration. While all are associated under the Society, each clinic has its own special interests and methods.

At Walworth, the parent clinic and the largest of the group, the superintendent is Mrs. Evelyn Fuller, a woman of great executive capacity. Her manual on the ideals of management and equipment for birth control centers should be consulted by any group contemplating such a project. (F-6) The Center occupies the whole of quite a large dwelling in a very poor working-class quarter. Though it is little more conspicuous than other clinics, most of which are retiring, Mrs. Fuller considers that it has "shop premises on a corner site."

North Kensington is used as a center for clinical study and experiment by the Birth Control Investigation Committee, which is making certain inquiries into methods and management, looking toward the broadening of the work both in its scientific aspects and in its service to clients. (Chapter VII) One of the physicians is a gynecologist. Medical examinations are more than usually thorough; follow-up is careful; and records, made on specially devised forms, are as complete as possible.

Evening lectures and discussions are held for patients, on birth control and allied topics. This clinic and Walworth are used as training centers for doctors and nurses, and medical students are invited to attend sessions at North Kensington.

Mrs. Margaret Spring-Rice is chairman of the North Kensington Committee, and the Honorable Marjorie Farrer, secretary and lay superintendent. Lady Sprigge, wife of the editor of the Lancet, a leading British medical journal, is active on the Committee.

At Birmingham, Mr. John Sumner, a local philanthropist, supplied the funds to purchase and equip the premises. Aberdeen has converted shop premises of four apartments. It is financed by Fenella Paton of Grandhome House, her mother, and half a dozen friends. Cambridge has patients from forty-three towns and villages. Oxford works with difficulty because of local opposition from High Church Anglicans, and the presence of a hostile Member of Parliament. For East London, Captain Gerard Leigh and Lord Ivor Spencer Churchill are financially responsible. From the clinic at Wolverhampton, a special extension service during 1927 and 1928 was offered to miners' wives. Clinics (not surveyed) were opened at Rotherham in 1928 and at Newcastle on Tyne in 1929, and additional centers will be opened as soon as funds are secured. The object of the Society is to provide all localities with special services, pending the time when the government health stations and regular outpatient departments shall assume responsibility.

The Pioneer Health Center at Peckham is not primarily concerned with birth control at all, though it prescribes contraception where needed. It describes itself

as "a research unit," doing intensive health work of every kind with a limited number of families. We have been obliged to enumerate its patients in Table I merely as "1 plus" because Dr. G. Scott Williamson, who is in charge, writes us that they do not "propose making use of any statistics before the end of five years." It is financed by Jewish philanthropists, although it is nonsectarian.

The Liverpool clinic is in a poor residence street about three blocks from the center of the city. It is staffed by a doctor and one or more nurses and has several commodious rooms, one flight up. They were unwilling to give our investigator, who called in person, any information whatever except that they followed Walworth lines, "not Stopes," which when said in England means especially that the cases are seen by a doctor, not a midwife, and that the Stopes appliance is not usually used. This reticence may not be unconnected with the fact that Liverpool has a considerable Irish Catholic population. Its letterhead bears, among others, the names of Lady Barr, Mrs. Barrett, Professor Carr-Saunders, the Lady Cozens-Hardy, Dr. Vera Foley, and Dr. Hugh Reid.

The clinic at Mirfield (No. 39), a place in Yorkshire of about 3,500 population, was formerly run in the labor union headquarters, but is now held alternately in the residence of the nurse and that of Mrs. Waddington, who was formerly for many years head of a great city hospital for women and children, and is now a local magistrate. She and one other nurse compose the staff. The branch at Goole is held monthly in a nurse's residence.

If one surveys the complete British list, it appears that none of their centers is in a "Main Street" town—a "city

of the Philistines"—unless it is the effort of Mrs. Waddington, working single-handed from her pleasant country seat in Yorkshire. Six are in London or its suburbs; a second in another great seaport (sea-going people are always liberal); four in four famous university towns (Nos. 31, 33, 34 and 36); two in two great industrial centers (Nos. 32, 35), famous for their enlightened working men.

In turning now to the American towns, we find something very different: towns of every sort in ten or more states are represented in this very modern movement.

NEW YORK AND EASTERN SEABOARD

The chief New York Center, and largest special birth control clinic in the world, is the Birth Control Clinical Research Bureau, located close to Fifth Avenue and Fourteenth Street. It was founded in 1923 by Margaret Sanger, two years after the American Birth Control League. It was a department of the League until late in 1927. Dr. Dorothy Bocker acted as physician for the first two years. Dr. Hannah M. Stone has been in charge since 1925. Though at present the League and the Bureau are entirely separate organizations, they have been identified so closely in the past, even to the extent of being housed together, that they cannot be considered entirely apart. In 1928 Mrs. Sanger resigned the Presidency of the League in order to devote herself to the Clinical Research Bureau, of which she became Director. Mrs. F. Robertson Jones, long Vice-President, became President of the League.

The League is now at 152 Madison Avenue, near 32nd Street. Many people from all over the world are con-

tinually received and answers are sometimes mailed to as many as two hundred inquiries a day. In a survey of clinics it is not possible to do more than mention the many activities of the League ably carried out on a national scale, including education, publication, legislative reform, and clinic promotion. Dr. James F. Cooper, author of the pioneer medical book on birth control (C-8), has for several years been the medical director, making many addresses before medical and lay groups. The field secretaries organize local committees and help in other leagues.

One reason for the separation of the two organizations was that the clinic might be divorced entirely from propaganda, which is foreign to one of the avowed objects of the Bureau; i.e., research. It was also hoped that the organized medical profession would show a more favorable interest in the clinic, if it were dissociated from non-medical activities, and this is gradually coming to pass.

At present the management of the Bureau is as follows: Mrs. Margaret Sanger (in private life Mrs. J. Noah Slee), Director, and Dr. Hannah M. Stone, Medical Director and chief of staff. Policies are directed by an advisory council of physicians and scientists, the former including Drs. Adolf Meyer, Stuart Mudd, Ira S. Wile, John Favill, John B. Solley, and Benjamin T. Tilton, and the latter, Professors C. C. Little, E. M. East, Leon J. Cole, Wm. F. Ogburn and L. C. Dunn, geneticists, and sociologists. Mrs. Francis H. Bangs is chairman of the Board of Managers.

The staff consists of Dr. Stone with twelve women doctors. Two doctors are on duty morning and afternoon every week-day except Wednesdays and Saturday afternoons, and there is one evening session, making eleven in

all. The office is always open for appointments, booked several weeks in advance. The full-time non-medical staff includes three social workers, one of whom acts as clinic executive, five trained nurses, and three clerks.[2] Doctor Stone volunteers her services, and the other doctors are paid a small fee. A branch service for negroes was opened early in 1930, in the North Harlem district of New York with partial support from the Rosenwald Fund, of Chicago.

In August 1928 a study was begun of the patients' histories as set down in the case records. After a preliminary report on 200 cases, funds were secured from one of the Foundations to undertake a complete analysis of 10,000 cases. An elaborate code was devised to cover fifty-five items and the material taken off on punch cards similar to those used by the U. S. Census. The figures are just at the point of being tabulated as this book goes to press, and the results should be published in another year. This will be the most complete presentation of data in this field, and of great usefulness to all concerned.

[2] In 1925, an attempt was made to secure a license from the State Department of Charities under the New York Dispensary Law. This was refused although all the usual requirements were met, including a demonstrated need, a satisfactory endorsement by interested groups in the community, a satisfactory location and assured support. The grounds for refusal were finally stated by a member of the Board of Charities to be the fact that the clinic is a specialty and that the Board did not contemplate the licensing of any further specialty clinics. However the Board pointed out that a license is not needed for a clinic which does not call itself a "dispensary" nor hang out a shingle, and that a large proportion of medical services in New York City, such as baby and maternal welfare, are not licensed. Accordingly the clinic has continued to run as the private office of its Medical Director, though it has the usual clinic equipment, staff, and administration.

The Bureau has been justly criticized for the absence of gynecologists and obstetricians on its Board, although it is actually one of the largest women's clinics, and also for the lack of regular medical supervision and inspection. The New York Academy of Medicine has now actively concerned itself in the matter, and a temporary subcommittee of the Public Health Relations Committee has been appointed to report on birth control in general, and in particular upon the Clinical Research Bureau, which welcomes this move, and offers full coöperation. The deliberations of this Committee will be taken in association with the results of the intensive study of case records just mentioned and should broaden the management and increase the clinic's potential value.

In Greater New York there are nine hospital clinics (eight given in Table I, Nos. 41 to 48) which give contraceptive advice. These are in the regular, established outpatient departments maintained especially for women, for obstetrical work, etc., by leading New York hospitals, and are under the auspices of the Committee on Maternal Health. These, like the Birth Control Clinical Research Bureau, operate under the laws and court decisions of the State of New York, and restrict contraceptive advice solely to married persons "for the cure or prevention of disease."[3] The patients are seen in every case by a

[3] Refs. W-11, R-9, D-12, D-13, D-16, D-17. In the present law no mention is made of married or unmarried persons being eligible for advice, but the amendment proposed in 1926, 1927, 1928, and 1929, read as follows: "An article or instrument, used or applied by physicians lawfully practicing, or by their direction or prescription, *for the contraceptive treatment of married persons or* for the cure or prevention of disease, is not an article of indecent or immoral nature or use, within this article . . . " (the matter in italics is new). In 1929 a Committee

physician, with the assistance of nurses, secretaries, and hospital social service workers in the usual routine of the women's clinics, which are of course occupied with fifty or a hundred times as many ordinary, old-fashioned types of female ailments as with birth control cases. Birth control, in fact, composes a new line of gynecological work, the greater part of which was inaugurated in 1926. Under the Section, "Source of the Patients," in Chapter V will be found an informal opinion as to who in each hospital takes the progress of this work most warmly to heart; that is, who constitutes the real "staff" upon which the work leans.[4]

The Lenox Hill Hospital is a large general hospital serving the whole city and located in a German-American quarter, not at all poor, but rather of the well-to-do working class. Mount Sinai, the largest Jewish Hospital in the United States, is on the border line between wealthy

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of the Medical Society of the State of New York was formed to report on birth control and sterilization, and future bills will be drafted after request for consultation with this Committee.

[4] The following physicians were designated (1929) by their colleagues on the medical boards of these hospitals to attend to the contraceptive work:

Hospital	*Physician Designated*
Jewish of Brooklyn	Dr. Adolph Bonner
Lenox Hill	Dr. E. W. Matsner
Mt. Sinai	Dr. Max D. Mayer
New York Infirmary for Women and Children	Dr. Helen W. Spencer
New York Nursery and Child's	Dr. C. E. Heaton
Sloane	Dr. V. G. Damon
Woman's	Dr. George Gordon Bemis
Beth Israel	(No clinic at present)
Lebanon	Dr. J. Milton Goodfriend

and poor Jewish quarters. There are also Jewish hospitals in Brooklyn and the Bronx on the list, the latter serving a very poor, new, rapidly growing Jewish community. The remaining four institutions on our list are distinctively for maternity and for women and children. The Woman's Hospital, affiliated with Cornell University, is in a good neighborhood. The New York Nursery and Child's is not far from the old Irish-American "Hell's Kitchen" neighborhood and the second largest colored settlement in New York. The Sloane Maternity Hospital of Columbia University, which serves the whole city, used to be in the same neighborhood, but has now moved far uptown and is included in the Medical Center. The contraceptive service is in the Vanderbilt Clinic, which comprises the out-patient departments of Sloane and Presbyterian Hospitals and the Neurological Institute. The New York Infirmary for Women and Children is on the East Side, on the edge of a distinctly poor Russian and Italian Quarter.

There are four other clinics on the Atlantic Seaboard. The Newark Maternal Health Center (No. 68, Table I), in the central business section, was inspired by the American Birth Control League in nearby New York, and is at present under the direction of Dr. Stone of the Clinical Research Bureau. The physician in charge is Elizabeth Pissoort. The Advisory Board of ten physicians has included F. A. Alling, W. P. Eagelton, W. B. Mount, and W. Bingham. (H-2)

The first *rural hospital* to offer contraceptive service is Grasslands, the Westchester County Hospital at Valhalla, N. Y. This, like the New York City hospital

clinics, is under the auspices of the Committee on Maternal Health.

The Baltimore Bureau for Contraceptive Advice, Inc. (No. 65), in a lower middle class district, is unique among American special clinics in owning its own home. It uses the first floor of its three-story private house for waiting-room, office and examining room. Bessie L. Moses, M.D., director, is assisted by a registered nurse and a secretary, and sees patients on three afternoons by appointment. Some distinguished names compose the committee in charge.[5] Patients must bring a letter from a physician or social worker saying that their health or financial condition does not justify child-bearing. (B-38)

The first Southern city to have an organized contraceptive service was Atlanta, Ga. where in the fall of 1929 a clinic was opened in the Grady Hospital, the leading general hospital with public and private support, and connected with the medical school. Dr. Frank Eskridge and Dr. Chas. W. Daniels are responsible for the work which is carried on as part of the obstetrical and gynecological department. Georgia has no prohibitory legislation affecting birth control, but it is planned to restrict the admissions to those with health problems (No. 70).

[5] Dr. J. Whitridge Williams, *Chairman*
Dr. Raymond Pearl
Dr. Donald R. Hooker
Mrs. William Bauernschmidt
Dr. Mildred C. Clough
Dr. Paul W. Clough
Mrs. Donald R. Hooker
Mrs. Henry C. Kirk
Dr. Adolf Meyer
Judge Jacob M. Moses
Dr. William H. Howell
Mrs. Richard L. Cary
Mrs. Caleb N. Athey
Miss Elizabeth Gilman
Prof. Jacob H. Hollander
Rabbi Morris S. Lazaron
Capt. L. Wardlaw Miles
Dr. Lilian Welsh
Dr. Mary Sherwood

ILLINOIS AND MID-UNITED STATES

The oldest and most active of the state leagues is that in Illinois, whose leaders have long been influential in the general work beyond state borders, and which is now directly affiliated with the national organization.

The Illinois Birth Control League houses its six Chicago clinics as follows (I-1): its headquarters (No. 49) in the same building with many organizations belonging to the Council of Social Agencies; another in the Polish district; another in the famous Hull House; another in a center for charities and medical aid; another in the stockyards district; another in a Jewish People's Institute. Dr. Rachelle S. Yarros developed the medical organization and is still the general medical director. Four attending physicians divide the work between them at the centers, Dr. Olga Ginzburg being most active. At the central office an executive secretary and a clinic secretary are responsible for the administration and records of all the clinics. At the Jewish Institute the service is all by volunteers except for the physician.

The Jewish Social Service Bureau of Chicago (L-8) maintains, not a clinic, but a sex hygiene service by its own two specially selected physicians, to whose offices patients are taken by the sex hygiene nurse. Many of these patients are from the degenerate classes. It has become the custom to take both wife and *husband* to physicians for instruction in all families where contraceptive knowledge has been requested, but to no family at any time has it been given without a written application from both husband and wife requesting it. Usually a year or more of follow-up visiting is done.

Still another piece of work in Chicago is similarly auspicious. At the Mandel Clinic of Michael Reese Hospital Dispensary the service (No. 56) is for sterility as well as excess fertility and a social worker gives half time to visiting the birth control patients in their homes. The staff consists of Dr. I. F. Stein, two other physicians and a nurse. Though cases are now taken only on strict medical indication and when referred by the other departments it is expected that the work may be expanded beyond these limitations. This hospital has one of the largest obstetrical services in the world.

The Detroit Mothers' Clinic (No. 64) occupies the basement of a large apartment house, converted into a suite of rooms with a separate street entrance. It cooperates with the Jewish Welfare Board, but only ten per cent of the patients are Jewish. The staff consists of Dr. B. B. Sherman, two other doctors and a nurse. Inclusion in the "Detroit Community Union" handbook results in all other agencies public as well as private coöperating.

The Cleveland Maternal Health Clinic (No. 66), prescribing for medical reasons only, employs a full-time nurse and two part-time physicians, Dr. R. A. Robishaw and Dr. S. Marcus. Its office is in a downtown building devoted almost entirely to physicians' offices. Its patients are of about the same low income class as those at Newark. The clinic is one activity of the Maternal Health Association, and is supported by private subscriptions, with a secretarial salary from the Brush Foundation. There is a strong medical advisory board.

The Cincinnati Academy of Medicine in the spring of

1929 started a Committee on Maternal Health, in close affiliation with the National Committee (in New York). In the fall they opened a clinic in the Cincinnati General Hospital in the Department of Obstetrics and Gynecology (No. 67). Birth control advice is only one part of a comprehensive program of preventive gynecology which also includes premarital examinations, conjugal adjustment, sterilization, therapeutic abortion, and the prevention and treatment of sterility. Dr. Elizabeth Campbell, a well known physician long active in public health and social hygiene, is chairman of the Committee, which includes leading names. Alice C. Boughton, Ph.D., is executive secretary, and Dr. Esther Wallner is clinical director.

The Denver Maternal Hygiene Committee, of which Mrs. Imogene Daly Fisher is president, has encouraged the Colorado General Hospital (No. 69) to provide contraceptive advice in its women's clinic for patients who need it. Voluntary sterilization has also been performed (free if necessary), chiefly on the more irresponsible class of women (V-1).

The special clinic (No. 63) in the metropolis of Texas is the private enterprise of two physicians, man and wife, whom I found upon personal investigation to be of excellent repute. They call their office a birth control clinic because they desire to be known to their friends as specialists in birth control, but they do not wish to "advertise"—hence, they remain anonymous in Table I and here. They use the methods and case sheets of the Clinical Research Bureau.

CALIFORNIA

The Los Angeles Mothers' Clinic Association, Inc. (No. 57) recently endowed with $180,000, has a suite in a regular office building which is open daily from nine to five, but its clinic under Dr. Etta Gray, with five woman physicians assisting, is held there three times a week by appointment only (L-4). Its staff comprises a director who is a social worker, a registered trained nurse, and an office secretary. Four men physicians serve respectively as president, vice-president, treasurer, and secretary. The founder was the late Dr. H. G. Brainerd, former president of the California Medical Association. The names of these persons make a very striking letter-head for a welfare organization, the whole group consisting almost entirely of medical men *and* women without the need of any bolstering laymen's names. This proud independence among California professional people confirms our impression arising from the mortality, literacy and wealth statistics, that the Pacific Coast has the most modern standards of civilization in the world (Y-2) (L-1). It is certainly very far advanced in birth control, for not only has it the fifteen clinics here mentioned, mostly endowed or official, but it has also its sterilization laws (described in the next chapter) buttressed by a strong medical and lay sentiment.

The Los Angeles County Health Department under Dr. T. L. Pomeroy has mothers' conferences, arranged for by the Child Hygiene Committee in nine district centers (No. 58). Patients are referred by physicians or institutions, and when they come for private appointments must bring with them written reports of their examina-

tions by a Health Department physician including Wassermann test and urinalysis. They must be victims of one of ten types of illness or deformity, or else their cases must be specially considered on their merits by the director of the division, Dr. Elizabeth M. Saphro. Dr. Nadina R. Kavinoky is the physician most closely concerned with the work.

At Pasadena, Dr. J. Severy Hibben is in charge of a "Mother's Clinic" (No. 59) connected with the Pasadena General Hospital Dispensary, for spacing children, etc. There is a staff of three persons, who take care of poor patients only, referred from the same Dispensary's gynecological clinic and from hospitals, physicians and social service organizations. Roman Catholics are accepted only with their Church's permission.

In the neighborhood of Berkeley, California, the work has been carried on despite interruptions since 1925, by the Alameda County Birth Control League, with Dr. Ann Martin as president. After encouraging the introduction of contraceptive service in the gynecological clinics in two of the public health centers of the county (No. 60), it started its own special station, "The Mothers' Health Clinic" (No. 61). The Health Center policy is to accept only the women who are "socially eligible for clinic care" namely the poor and "all Catholic patients are first referred to their priests before being admitted to the clinic. This policy cuts down greatly the number of cases treated, as the majority of the women who apply are Catholics. It has been thought best, however, to avert criticism by keeping to this rule" (B-19).

In San Francisco the American Association of Univer-

sity Women have, in connection with their children's health center, a clinic (No. 62) under the charge of Dr. Alma Pennington, with Dr. Adelaide Brown as chairman. Stanford University Hospital coöperates by sending such patients as need birth control. This group is also studying sterilization.

GERMANY AND AUSTRIA

In the German countries there is a widespread movement to improve sex relations. Official municipal centers (Eheberatungsstellen) advise brides and grooms about venereal infection and other difficulties, try to prevent divorce, to increase physical and mental hygiene among married couples, and in every way to stabilize and improve marriage. Private centers do the same, and in addition, more often assist with birth control, and also extend their services to the sex difficulties of the unmarried.

All these marriage and sex-advice stations, including those in Table I, operate by referring the clients to hospitals or to the required specialists (legal, medical, psychological, and social service experts) rather than by having the specialists present at the stations. In centers where much of the work comprises birth control, one wonders why they do not employ a gynecologist at least in the station. In Vienna we were told that the professional medical organization was opposed; in Berlin, that the Bund für Mutterschutz—the German society earliest interested in birth control—did not wish to awaken the attention and opposition of the profession or of the Catholic Welfare Minister of the Reich. And no doubt the chief reason everywhere is the conviction that the German birth

control movement is strengthened by retaining merely its proper modest part in the whole great medical-psychologic-social-service movement set on foot by Freud, Jung, and other notable thinkers.

One difference between Austria and Germany is that most of the German gynecologists donate their services to the clients referred to their offices, but in Vienna they are obliged to charge, no doubt because of the more severe economic depression affecting the professional classes in Austria. Nevertheless, though the German patients are referred to outside gynecologists, they are all interviewed at the center by a physician (N-4), except at Breslau (No. 13); also by a social worker, except at No. 6, at Dresden (No. 1), and at Dr. Dehmel's (No. 15). The Austrian centers shown in our Tables have only a volunteer present at the center. German centers Nos. 1 to 5 are under official municipal auspices, as are Nos. 7 and 8, and Nos. 7 to 13 are supported by the Bund für Mutterschutz, of which Dr. Helene Stöcker is president, and all except Breslau are situated in official buildings (B-37) (N-4). Mannheim (No. 12) is one of these Bund Centers. Chemnitz (No. 14) is under another humanitarian organization.

The most important development of 1929 was that the public sickness insurance (Krankenkassen) of Berlin began to give contraceptive materials gratis to its members, especially at five centers (See Appendix C). The cases exceed two thousand so far, according to Dr. Ruben-Wolf.

The type of work in Germany may be judged by some figures from No. 9, the Frankfurt Center of the Bund für Mutterschutz, in charge of Dr. Herta Riese (R-4) (M-4 p. 219). Three-quarters of the clients were women,

ninety-five per cent of whom sought advice on family limitation, nearly half by interruption of existing pregnancies and the remainder by contraception. The former were refused except in those cases in which a condition of ill-health made abortion legal. The legality of abortions was determined in a hospital to which the director of the Local Sickness Insurance Fund (a government official) secured the admission of the patients.

The Hamburg centers of the Bund reported as follows: "The work of the coöperating physicians, lawyers, educators, and social workers is given gratuitously. The centers are not run on any particular system. So far as seems necessary, the clients are referred to a physician or to another institution; also our centers work hand in hand with the official children's bureau and other welfare bureaus" (B-37, p. 215) (M-4). The centers in Hamburg and Frankfurt are all three located, free of charge except for cleaning, etc., in the rooms of the Allgemeine Ortskrankenkassen (official Sickness Insurance Offices).

The Institute (No. 6), which will eventually be connected with the University of Berlin, is directed by Dr. Magnus Hirschfeld (H-6) (M-4). It is used by classes of the University for observation, mostly on cases of perversion.

The German clinics Nos. 3, 7, 9, and 16 are staffed by women doctors, but unfortunately nearly all of the others have only men. Dr. med. Martha Ruben-Wolf is an important leader in Berlin, and is, together with other women physicians of Berlin, especially interested in Clinic No. 16 under the Komitee für Geburtenregelung. The Komitee was organized following a visit by Mrs. Sanger.

VIENNA. The eight Vienna institutions numbered 17 to 24 in Table I are under Johann Ferch, and are situated in each quarter of the city (F-1).

The central office (No. 17) in the charge of Frau Ferch and doing two-thirds of all the work, was visited by us. It is in the Central Labor Union Building, which while owned by the Arbeitervereinen, is really under governmental control, because of the inextricable mingling of unions and government in Austria for the administration of workers' insurance. The building has a large lecture hall and forty offices whither the working people are privileged to come for medical treatment, and are compelled to come for unemployment and other insurance payments. One of these medical offices is turned over for non-medical use two hours a week to the Bund für Geburtenregelung (Birth Control League), formerly the "League against Forced Motherhood." Two, or sometimes three, volunteers enter case records (under number, not name, as they take unmarried women) for the women who come. Then those not found already pregnant are referred to one of a selected list of forty physicians who prescribe contraceptives in their own offices. The pregnant are dismissed unless a serious physical condition makes interruption (abortion) probably legal, in which case they are referred to a public hospital for a diagnosis supporting the legality, and for the operation.

The procedure is the same in the branch centers, all but two of which are also housed in official buildings, three indeed in the *Amtshaus* or the *Bezirksvertretung* of their district, and one in a welfare institute and two in sickinsurance headquarters, one general and the other for street-car conductors. Twenty per cent of the able-

bodied were still out of work in Vienna in 1927. It is to them that the service especially ministers, but under terrific financial difficulties. See Chapter V. The same work by Herr Johann Ferch and his League for Birth Control[6] seems to be carried on in the provinces at less frequent intervals and with less regularity.

PERSONALITIES IN CLINIC BUILDING

In conclusion, it will be interesting to name the persons whose characters have been adequate to the task of organizing these seventy birth control centers in the face of an almost overwhelming conspiracy of silence or open opposition.

Marie C. Stopes, D. Sc., is the pioneer in England in practical clinic building—a woman in whom a superlative education has not been sufficient to quench the fighting spirit. She is the author of several books with world wide circulation. (S-23)

Margaret Sanger is the pioneer in the United States—a woman little surpassed by the best of the pioneer woman suffrage leaders as regards oratory, intellectual caliber, and the courage to go to jail for her convictions, and adding to these qualities great personal charm and a deep compassion for the poor.

Concerning the Chicago leaders, one may well ask how it is that this city has eight clinics while scarcely any other American city has more than one. The explanation must be found in the coöperation of certain persons of high standing in Chicago life. Among these are Mr. and Mrs. James A. Field and others of similar prominence. Also, the medical director of the clinic, Dr. Rachelle S. Yarros,

[6] Bund für Geburtenregelung, Wien VI, Gablenzgasse 31.

is an outstanding personality, a lecturer of unique appeal; and Mrs. Benjamin Carpenter, the president, is a natural administrator, and well acquainted, as was her father before her, with most of the leaders in Chicago finance and charity work. Mrs. Carpenter has coöperated with the New York leaders to do in this country what Mrs. Fuller is doing in England; that is, coördinate the various birth control agencies.

Of Mrs. Fuller we have already spoken. The distinguished publicist and lawyer, Harold Cox, has been invaluable in England in defending court cases and is Treasurer of the Society for the Provision of Birth Control Clinics, of which the Honorable Mrs. Graham Murray, O.B.E., is chairman, and Mrs. Fuller honorary secretary. Dr. Norman Haire, an Australian by birth and training, was the first English physician actively to take up clinic work. The Honorable Mrs. Marjorie Farrer has been active in developing the scientific basis for the clinic work, together with Mrs. Margaret Spring-Rice, wife of a nephew of the late British Ambassador to the United States, Sir Cecil Spring-Rice, and leading woman in the National Liberal Party.

Mrs. Cora B. S. Hodson, educational secretary to the influential English Eugenics Society, is a biologist and physiologist of high standing, and a polished and effective speaker. She has also been instrumental in converting her organization to the principle of allowing birth control an enthusiastic trial as a eugenic measure.

Johann Ferch, of Vienna, is a pamphleteer and lecturer, a man of the people, self-educated and full of compassion for the unfortunate. He and his wife have done a marvelous work without any assured financial support.

Birth control is but one phase of Dr. Helene Stöcker's life work as a publicist, given unstintedly and without hope of reward, in behalf of Germany's women, especially the unmarried mothers and their children, who comprise one-tenth of all German children. She and her Bund für Mutterschutz[7] also work against German militarism as well as against illegitimacy and for birth control.

The practical work in Holland was organized by Dr. J. Rutgers and his wife, Mme. Rutgers Hoitsema, and by Dr. Aletta Jacobs, Holland's great pioneer woman physician. See Appendix C.

On Russian personalities, we regret to acknowledge ignorance. The contraceptive work is being promoted actively by the government public health officers.

There have been many others interested in population problems, but they have lacked the desire or else the administrative capacity to create large practical centers for birth control. Those who have been gifted with this desire and this capacity seem to us characters of very great strength.

[7] Headquarters of the Bund are in Berlin-Nikolassee, under the direction of Dr. Helene Stöcker. Provincial leaders and correspondents are as follows: Rita Bardenheuer, Bremen, Franziusstrasse, 19; Marie Hübner, Breslau I, Garvesstrasse 29; Gertrud Stern, Chemnitz, Bauhausstrasse 19; Elsa U. Bauer, Frankfurt A. M., Bürgestrasse 83; Dr. med. Georg Manes, Hamburg 26, Diagonalstrasse 4; Stadträtin Martha Harpf, Königsberg i. Pr., Regentstrasse 5; Elisabeth Blaustein, Mannheim B I, 7b; Vorsitzende und Anschrift für alle Mitteilungen: Victorine Hausmann, Nurnberg, Harsdorferplatz 1. (Die Neue Generation, 23 Jahrg. Heft 5, May 1927, p. 190.) The last two names and places no longer appear in the Bund's journal during 1929, but the other names remain the same.

CHAPTER II

THE CASE PROCEDURE

The actual present practice of handling cases is described in this chapter, while general questions of medical policy and organization are dealt with in Chapter VI.

Eligibility. The custom of the clinics is to refuse to advise unmarried women or to interrupt existing pregnancies; nor is a pregnant woman even advised how to avoid subsequent pregnancy. She is merely urged to return again after childbirth. Exceptions to these rules will be found among Germanic clinics and also in those American hospitals where the contraceptive work is associated sometimes with the therapeutic interruptions (abortions for legal medical reasons). One of the aims of the whole movement is to persuade hospitals generally to discard their century-long practice of performing relatively numerous abortions on women in bad health, and to adopt the method of using forethought to prevent abortions altogether where they are certain to be necessary if the woman becomes pregnant. In other words, hospitals should *prescribe* contraception in order to *proscribe* abortion.

Methods Prescribed. The actual processes and instruments and materials are not detailed in this study, because to do so would run counter not only to the postal laws, but also to the wise and settled policy of most birth control leaders in the United States; which is, to leave the prescription of contraceptives to doctors, and discussion

about them to the medical publications. (Refs. S-10, S-20, S-21, S-22, P-13, C-8, M-15, H-1, D-13, D-14, D-15, D-16; also additional medical references at end of Bibliography.)

This policy is called wise because, though it is slow in bringing relief to suffering, any other would be unfavorable to decorum and to safe hygiene.

It may be observed, however, that there is a uniform trend toward the prescription of one type of appliance for the sort of cases seen in the clinics. Its chief merit, especially among the less responsible classes, is that it places a woman's protection in her own hands, so that she is no longer at the mercy of a drunken or careless husband. Its chief limitation is that it is not readily available except in the hands of the specialist or one with training in the best use of the method, particularly in the case of women who exhibit injuries of childbirth. Such exceptionally equipped services as those at Mt. Sinai Hospital in New York and at Mandel Clinic in Chicago are experimenting with other methods adapted to the needs of the individual patient. Recently two new methods have been developed in Germany, one especially sponsored by Dr. Gräfenberg. The Bund für Mutterschutz has used the methods of Dr. Brupbacker, which also agree in fundamental principle with those generally adopted elsewhere. (B-35)

The Case History Forms. The patient is received and a case sheet is made out by a nurse at most clinics.[1]

[1] The author has a file of the various case history forms to which inquirers may refer, but none for Germany except for Berlin "Bund" centers. A sample sheet is discussed in Chapter VI. Case sheets are uniform with Walworth in Nos. 29 to 34, and in 36. North Kensington uses a form specially prepared by the Birth Control Investigation Committee, in some ways the most effective yet devised.

At Vienna and Walworth a volunteer does this work, and at the Illinois League and Los Angeles, a secretary; in Germany, a social worker—professionally trained in five of the clinics. In Vienna case sheet records have only been kept since 1927.

While the German and American blanks contain provision for detailed records, far fewer questions are asked at the English clinics because, according to the view of the English philanthropists, most of the patients "are shy and nervous at their first visit and everything possible should be done to invest the proceedings with an atmosphere of privacy and friendliness." (F-6) But all the great well-known clinics—Stopes No. 26, New York No. 40, Walworth No. 27, those of Illinois and the Berlin Bund—ask address, date of marriage, age of wife, number of children alive and deceased and of miscarriages, husband's age and occupation.[2]

SPECIALIZED LINES OF INQUIRY

Many of the case sheets carry additional inquiries, some in one direction, others in another. These may be *eugenic* in their intention, investigating the health of two or three generations (Berlin "Bund," Stopes, Vienna, and most of the American clinics), or they may be *medical* and *psychosexual.* Again, attempts of interest to the eugenicist are made to determine *social status* by inquiring concerning wages, education, rent and number of rooms, etc. California succeeds best here. For further discussion of

[2] Though this last word is not printed on the Stopes questionnaire, the nurse claims that she asks for the husband's occupation. The Sanger clinic does not ask his age.

eugenics and social status, see Chapters IV and IX and Appendix A.

As regards psycho-sexual and medical questions, the somewhat similar sheets used in nine New York centers, in Newark, the Mandel Clinic, Southern California, Detroit, Baltimore and Cleveland, are the most thorough. Walworth asks no sexual details except dyspareunia, but it has careful questions on physical conditions. However, the prompting words to the physician are anatomical, rather than pathological after the American custom which uses the words: "laceration, displacements, inflammation, tumors, congenital defects."

Persons interested in full medical diagnosis and in all phases of birth control which are medical rather than social will be wise to follow the writings of Dr. Robert L. Dickinson,[3] including Chapter VI in this volume. He volunteers his full time to the Committee on Maternal Health, which welcomes professionally interested visitors to its offices in the New York Academy of Medicine, at Fifth Avenue and 103rd Street. This Committee, which is of national rather than local scope is described in Chapter VII.

This Committee has induced a dozen leading hospitals

[3] Senior gynecologist and obstetrician, Brooklyn Hospital; former Clinical Professor of Obstetrics, Long Island College; Assistant Chief, Medical Section Council of National Defense; Lieutenant-Colonel and Medical Adviser to the General Staff during the European war; sent on government mission to China on United States Public Health Service, 1919; former vice-president Clinical Congress; Former Chairman Section on Obstetrics, Gynecology and Abdominal Surgery of the American Medical Association; ex-President American Gynecological Society; former President New York Obstetrical Society; author of some hundred odd articles.

to make very full records of their contraception cases on special uniform case-sheets with which it supplies them. (Nos. 41–48 and Nos. 56, 57, 67 and 70.) This sheet, being too lengthy for the ordinary clinic, was cut down in some of its medical and eugenic-social status items and made the basis for the form used by the Birth Control Clinical Research Bureau, and most other unattached clinics in the United States.

The medical examinations appear to be made by physicians in all cases except at Nos. 13 and 39, and at the Stopes Clinic (No. 26). At the latter, a large proportion are merely superficial examinations made by certified midwives. One is uncertain whether all of what are called their "907 difficult cases" have been seen by a physician (S-24). These cases difficult to fit with the contraceptive appliance are said to have formed only two per cent of the total cases of the year 1922, rising to 34 per cent of the total cases of the year 1924. The 907 difficult cases out of about 5,000 consisted of 496 with slit cervix, 196 with serious prolapse, and 215 with other malformations. But there is no space on the case sheets for notes on the medical examination, so these records must have been kept separately.

The work, however hasty, in this clinic as well as in others, nevertheless results in discovering and referring to hospitals many cases of tumors and birth injuries unknown to the patient or her advisers previous to the clinic visit. Thus Los Angeles' first report on 251 cases showed that 34 specialists' examinations were actually made and 59 references to special clinics.

It is Dr. Dickinson's opinion that an outline for a mini-

mum diagnosis should be worked out, and followed consistently in each case. The record forms developed by the Committee on Maternal Health merely allow space after the words "General Condition" and "Pelvic" and "Laboratory Reports," without setting down items to be checked as is done on some other forms.

Dr. Dickinson noted that the single line or so for "Diagnosis" on the Illinois League sheets has been filled out more illuminatingly under the direction of Dr. Rachelle S. Yarros' staff of physicians than on more ambitious sheets. The same may of course be true of the single line, "Sex Organs," used for all kinds of German Bund cases, whether these cases are contraceptive, psychotic, or what not.

There is no doubt that the doctors in all the clinics are often too busy to fill out all that is asked. It is probable that items on the sex life can not easily be secured from women patients by an unmarried woman doctor, nor always by a man, and are not commonly touched upon if the patient is reluctant.

One suspects that in Vienna and in Nos. 25, 38, 41 to 48, 55, 58 to 60, 69, and 70, the medical records are not centrally available, or that they are lost in a mass of other cases.

THOROUGHNESS OF TEACHING

That a woman should learn properly to use the contraceptive favored by the clinic is of the essence of the matter. Indeed, attention to detail is necesssary in using all types of contraceptives and one may thus explain why the Katharine B. Davis series of women (D-6), who are mostly college graduates, usually report something like forty per

cent *more* success with each self-prescribed method than Dr. Dorothy Bocker's clinic patients (B-29), who were of the less educated classes.

When one asks how much of the staff's time is consumed by each patient at the first visit, the reply, "twenty minutes," is commonly given as a minimum or average.

In Austria, however, much more of the physician's time is consumed because, by their system, the woman returns once a month indefinitely for the service that in other centers she is taught to perform for herself. This difference perhaps results from the fact that poverty-stricken Vienna must use a cheaper material more difficult to work with, and no teaching is necessary except to instruct the woman to abstain from intercourse during menstruation and to visit the physician as soon as it is over.

Some clinics, notably Walworth and New York Infirmary, may give as much as an hour to teaching an occasional woman, including time allowed her to get over her timidity. Clever women may learn in five minutes, with the possibility, however, of not feeling very confident about the technique. As assurance and ease of mind are important psychological factors in keeping a woman satisfied and willing to persevere with a method, it is well for all, both dull and clever, to return at the end of a week and demonstrate an actual mastery of the device. Many clinics, notably Mt. Sinai, depend more upon this return visit than upon exhaustive teaching at the first. At Kensington, one fifth of the patients were retaught, and this may account for the small number of failures they seem to have had (H-4).

Walworth, while bribing the patient to make a second

visit within a week, seems to be uniquely efficient at the first visit, and also effects an economy in running expenses, by the following device: It has four gynecological couches which can all be used at once for examination and instruction. One doctor and one nurse pass back and forth among four patients, but the patients, each being in a separate curtained cubicle provided with its own examining table, are not disturbed or hurried, and are allowed plenty of time to collect their thoughts for the purpose of mastering the technique. Thus Walworth runs off five patients an hour, although one who needs as much as an hour may have it. This scant degree of privacy, however, would probably seem inadequate in New York, where well-to-do women must often seek the Research Bureau because of the American taboo which keeps their own physicians ignorant and useless to them in the matter of contraception. In no other kind of out-patient service are actual separate rooms (not cubicles) so necessary as in the discussion of conjugal behavior. The Woman's Hospital (No. 43) provides the last word in privacy but these quarters are chiefly for gynecology and obstetrics, and only incidentally for birth control instruction. (See Chapter VI)

Los Angeles writes that they find it takes from a year to a year and a half entirely to eliminate fear that the contraceptive may fail; that when the patient thoroughly understands how to use it, she seldom "forgets" to do so; and that the careless mother who runs a chance and becomes pregnant seldom "forgets" a second time.

Conditions of leisure such as those at Walworth are notably lacking in at least one of the New York hospital

clinics, and this fact was used by the doctors at that clinic as the explanation of their lack of enthusiasm for the work. With the sparse accommodations continually in use for patients with all kinds of female disorders, there could be no concentration by nurse or doctor on a leisurely training of the scattered contraceptive cases.

The system of teaching at Chicago Jewish No. 55 is of as great interest as that at Walworth. Though the patient is examined in the office of a gynecological specialist, the teaching is done afterwards by a sex hygiene nurse in the patients' own home, the environment which is, of all, the most to be preferred. (L-8) They state that they usually carry each case at a cost of $40 over the one-year period.

These cases are as difficult as any series in any of the seventy clinics—probably more so—and the teaching is incomparably thorough, with cost and eugenic effect correspondingly high, as will be shown in later chapters on these two subjects. The Jewish report remarks, in discussing its seven cases of low intelligence for which sterilization was arranged: "There has been sufficient success with (other) subnormals, however, to indicate that low intelligence in itself is not always a certain cause of failure;" i.e., failure to teach contraception. (L-8)

Walworth receives defectives sent by the Officer of Health.

IS ANY ONE UNTEACHABLE?

Mrs. Sanger, Mrs. Fuller, Mrs. Carpenter and others agree that there is a class which cannot be trusted to use the methods taught by the clinics. For instance, there is the affectionate, unreflecting type known to housing ex-

perts, who, though living in one room with several children, will keep a St. Bernard dog. Such people will relax birth control at times.

Mrs. Carpenter, who is president of the Illinois League, writes us as follows:

"We find that our method is meeting with a very marked success. We have failures, of course, but in almost every case when a full investigation is made, we learn that the fault lies with the patient and not with the method. The most unsatisfactory class is that sent to us by the United Charities, which organization pays us a nominal fee for the women sent to us by its representatives. These women are, for the most part, ignorant, unclean and lazy, and it is very difficult to impress them with the need of doing something for themselves. They are in the main the poorer class of Lithuanians and Poles. On the other hand, we find that the colored women who come to us for instruction coöperate exceedingly well."

Mrs. Florence at Cambridge is very pessimistic (*Birth Control on Trial*, Allen & Unwin, 1930; C-1):

"A few facts emerge clearly. The foremost difficulty is the absence of any contraceptive method so simple and so effective as to meet the needs of the over-tired, feckless, under-housed, unintelligent or mentally deficient women. This lack was mentioned in our previous report, and the experiences of the intervening year have convinced us anew that the class whom it is most desirable to restrain from propagating will not be adequately reached until some new and simpler method of contraception has been devised. . . .

"Special care has been taken to gather and analyze data concerning . . . pregnancies which occurred after the patient had been taught the use of a contraceptive. . . . About 30 per cent of the first year's cases became pregnant. Of these, only six could be found who claimed to have used" . . . the method as directed.

A worker in the American Birth Control League has said that it is no more difficult to teach contraception than to teach people to cleanse their teeth. Yes, but how diffi-

cult is that? Let mothers or school nurses answer. Mrs. Sanger stated at the 1924 legislative hearing at Albany (B-15) that any mother able to keep a nursing bottle clean can use contraceptive methods successfully and that "others should be regularly cared for in public clinics" (as in Austria by their physicians?) "or, under certain special conditions, should be sterilized."

STERILIZATION AS A LAST RESORT

The unteachable must be turned over to the consideration of another body of people, those interested in therapeutic or eugenic sterilization which does not involve unsexing.

One of the major studies of population problems is that directed by E. S. Gosney of Pasadena, and now after some years turned over to the Human Betterment Foundation which he has provided. (G-3) The attempt has been to investigate every phase of the workings of the California sterilization law, in force since 1909, with 6,255 operations up to January 1, 1929. (D-18) The field work was done largely by Paul Popenoe, and the whole project has been assisted by a distinguished advisory committee including among others David Starr Jordan, Prof. Lewis M. Terman, and Prof. S. J. Holmes. The method of *voluntary* sterilization of many persons unable to propagate children above the feeble-minded class opens up untold possibilities. Where the state decides to offer it to such persons when they come to public hospitals and charities, they are often willing to accede because they have such difficulty in the competitive struggle that they shrink from the added burden of children.

As regards sterilization vs. contraception, Dr. Kavinoky of Los Angeles comments that the health balance of most patients leaving a sanatorium is too precarious to risk an operation either for sterilization or abortion.

THE FOLLOW-UP WORK

Follow-up is very necessary both for the greater benefit it gives the patient and to enable the clinic to determine the success of the contraceptive method, but it is difficult to carry out. This difficulty is not peculiar to contraceptive health work, however. Statistics collected by Michael M. Davis show it to be the main weakness of all out-patient and clinic work. (D-7) The patients tend to lose interest after the initial visit. In 1911, the Boston Dispensary found that "in one-third of the cases no result was reached because of the failure of the patients to return for the treatment which the first visit had shown to be required," (p. 291). Only one or two visits were made by half these adult medical patients in 1914, and half the eye patients never reached the stage of getting glasses. Seven important pediatric clinics in New York reported that only half of the child patients returned as often as twice. Patients suffering from venereal disease return even less frequently.

Clinics in keeping statistics of revisits often fail to divide them into the classifications "immediate" and "later." Even then analysis must allow for the reservoir of total past patients which may be drawn on, and for the distance into the past covered by the reservoir. Without this information the figures are useless for any but budgetary purposes.

The revisit after a week for the purpose of solidifying in the woman's mind what she has learned is very important and is emphasized everywhere except at Stopes (No. 26) and Pasadena (No. 59), and perhaps in Germany. Some clinics ask for two immediate revisits. But since patients are often too poor or live too far away to return, many must, and do, master the method in one visit. Walworth, in its usual business-like way, and Kensington coax the patients back by withholding until the second visit the sale to them at half-price of some of the supplies. At Kensington, 77 per cent returned for this second visit. (H-4) It is probable that those who are too careless to return would probably be too careless to renew the supplies if they did receive them at first. Walworth writes to patients at the end of a month if the second visit has not been made. Then, in a year, as far as possible those on the inactive list are written to, with a post card enclosed for reply, all ready to be filled out with a minimum of effort. Letters continue to be sent until three have received no reply. In the case of women who could not be helped at first because of pregnancy or for some other reason, four form letters are used.

The "active list" comprises those who are returning to buy contraceptives. From one-third to one-half of the "inactive list" are eventually rooted out of their inactivity. For three years the revisits have been 3,000 annually while the new cases had been running about half as many. (S-14)

Efforts to Get Complete Records. The leading centers in New York and Chicago employ field workers to visit the patients neglecting to report ultimate results by

mail. This expensive effort has been felt necessary because without it the doctors cannot know whether the contraceptive, if and when used, has actually given protection.

Figures have been published which show the difficulty. (C-8, p. 191) Out of a thousand inquiries by mail, the Research Bureau in New York heard from only a third. Field workers were sent to visit half of the remaining patients, or about 357, but only 109 were found to be at home, willing to talk, etc., and of these, only one-third were using the method. Kensington had about the same proportion (30 per cent) of field visits made from which the investigator returned without a full report. (H-4) Results will be further dealt with in the next chapter.

It thus appears that many on the inactive list in any clinic have probably dropped the method. Is it to be supposed then that those on the active list are sufficient to show the approximate percentage of medical success with a given method? Possibly. But the doubt remains as to whether the method is an important medical success where so many wish to drop it.

This whole question of successful follow-up is most important, but its practice varies even within the same clinic. The Research Bureau in New York when two years old averaged 138 new cases a month during 1925, with about 109 revisits monthly. In later years they have had more revisits. But Los Angeles in its second year reported 2,120 interviews with only 353 new cases. (L-4) Their third year is less intensive: 751 new patients with rather fewer interviews. But even this is a record to be envied by nearly any kind of clinic anywhere, and shows a very

high rate of return by nearly all patients. It appears that as we go westward through the Chicago Jewish visiting service and finally to Los Angeles, the work becomes more scientific and intensive—and for no reason apparently than that standards are higher. And these standards of living and civilization are high because population pressure is much less, per capita wealth much greater (L-1), and the philanthropists who aid the poor less burdened with a giant task. The Los Angeles clinics can when necessary coöperate with social workers and public health nurses to keep in touch with the patients, but farther east such civilized coöperation has not yet been attained, since the opposition of religious organizations and "Bourbon" politicians is able to prevent it. It is only fair to say, however, that such coöperation exists in some great German cities with their large socialist population and their vast social insurance machinery.

SUPPLY OF MATERIALS

The European centers do not have any trouble getting whatever supplies they need, as the best appliances, etc., are made in Europe and are shipped freely throughout Northern Europe. But in Italy there is now no doubt much difficulty. In France, however, in spite of her savage-sounding law, Dr. Stopes' book is sold by any bookseller (who nevertheless takes the law as an excuse to inflate the price), and the sale of materials for contraception is even more untrammeled.[4]

It has been difficult for Americans to get certain European articles, which were superior to those of domestic

[4] See Chapter VII for the French and Italian laws.

make, past the customs. Our Federal Government has stopped shipments of supplies even when destined for university clinics. Now, however, at least five American firms are manufacturing excellent articles both on the Atlantic and the Pacific Seaboards. Clinics usually supply the patients with nearly all necessities, the Stopes clinic being an exception.

SERVICE BY MAIL

Scarcely any of the centers in Table I supply physicians or other persons with information or materials by mail. Exceptions are the Illinois Birth Control League and the Research Bureau, which occasionally send supplies to physicians who are unable to secure them otherwise. Dr. Stopes has written or given descriptive literature to more than 30,000 persons outside her clinic, and states further: "In addition to these directly helped some hundreds of medical Practitioners, Midwives, Trained Nurses, Health Visitors and others have come to us for help and instruction in methods which they have thereafter handed on in their own localities of work." (S-24)

Service by mail to clinics and doctors is rendered by the Committee on Maternal Health which, on request, sends instructions to physicians in very careful detail, and in cases out of the ordinary puts the family physician in touch with the particular specialist he needs to advise him, or gives personal interviews at its offices in the Academy of Medicine. Physicians visiting New York are also glad to avail themselves of the skill of Dr. Hannah M. Stone at the Research Bureau. She has the figures in her favor, as the next chapter shows, when it comes to a record of practical working success among all ranks of society.

The Malthusian League of England, 122 Victoria Street, London, founded in 1877, is the oldest birth control society in the world and the parent of the Walworth Clinic, and hence of most other English clinics. "Of late years the League . . . has sent out 94,000 free leaflets giving information about methods of birth control." (K-3)

The Mexican Government has also distributed over 100,000 pamphlets teaching practical methods, according to Miss Mary Winsor, who visited Mexico City in March, 1927.

The Bombay Birth Control League gives by mail as much information as it is possible to transmit in this way. (P-5)

But the most significant of all these mail services is that of the American Birth Control League. (B-11) Not only are physicians technically instructed by the medical director, but a general correspondence is carried on with many thousands of persons, 8,510 in 1927 alone, and at the rate of 100 per day during certain long periods. Among these are women all over the United States who are overburdened with childbearing and in immediate need of definite contraceptive help. (S-2) The League endeavors to extend to them the only aid that it legally can. It tries to put the woman in touch with a physician in her locality who may possibly aid her. For this purpose, it has a list of many hundreds of physicians who have shown a disposition to help these troubled women to postpone or prevent—but of course never to terminate—pregnancy. A certain faithful, long-suffering few of these doctors can be depended upon to help a woman in need of contraception no matter how poor and disagreeable a patient she

may be. There is a further list of about 20,000 doctors whom the League has reason to think are somewhat interested. It is said by the League that one doctor out of every eight in the United States has at some time written to ask for information. (D-13, p. 9)

In September, 1929 the League was handling about twenty-five letters a day from appealing women, and to about one-fourth of these it was necessary to reply that there was no birth control clinic or listed physician within reach, but if her own physician would request it, the League's physician would confer with him as to her condition. It must be remembered, however, that many of these women have no personal physician and are not in the habit of seeking medical help of any kind, while many others have already appealed to their physicians in vain. Consequently, replies are seldom received from those who are directed to their own hypothetical "family physician," and of the remaining three-quarters who are directed to a clinic or special birth control physician, it is suspected that many never summon the courage to go. To meet this situation a tentative appropriation of money has been made by the League to see what can be done, first, with the quarter who are not in easy reach of known help. An effort is being made to bunch together a dozen or so of these cases and to enlist a charitable person in the locality to make appointments for them all at the same time with a physician engaged to determine whether they are properly entitled to contraceptive advice, and if so, to supply it. This may take weeks or months to negotiate, for any set of women. An administrative technique of this sort would eventually be applicable to those of the

other three-quarters within reach of medical assistance, whose letters indicate them to be ignorant and helpless.

Another league is instituting a similar physicians' reference service, although this is directly contrary to a statute of the state in which it operates. This League depends upon the opinion of the leading professor of medical jurisprudence to the effect that the obstructing statute is unconstitutional, being an invasion of the sacred right of every physician to save life and health, and of the right of every citizen under the Constitution to freedom of speech.

A number of factors combine, in my opinion, to make the American Birth Control League, of which Mrs. F. Robertson Jones is President, one of the most active and far-reaching of all humanitarian centers now existing. These are: its extensive mail service; the large Clinical Research Bureau near by; the publishing of the "Birth Control Review," of which Mrs. Mary Sumner Boyd was for a long time managing editor, and which is the leading journal in its field, having sold 51,600 copies in 1927. It is a popular journal, but it cannot be neglected by scientists, as important articles and statistics appear in it from time to time; for instance, Prof. Paul Lubinsky's recent article on Russia. (L-7)

CHAPTER III

SCIENTIFIC DATA OBTAINED AND SUGGESTIONS FOR HANDLING IT

THE very full case sheets used in many clinics for their thousands of patients generate a wealth of raw statistical material. A start has been made in studying it, as described before, by the Clinical Research Bureau, and also by the National Committee on Maternal Health in this country and the Birth Control Investigation Committee in England.

This chapter and the next deal with the groups of data which have seemed to merit particular study. Other groups appear later, and none are entirely omitted except *nationality of patients* and *why each patient desired birth control.* (C-8) (Y-1) (I-1)

Concerning the latter, we note that the economic reasons predominate, with health next, and spacing of children comes third but infrequently.

The psycho-sexual and medical findings have not, so far as we know, been collated, except by Dr. Stopes as already described.

No elaborate studies have been made on age and net fertility of the patients beyond scattering reports similar to those summarized in Table IV. Columns 8 and 11 show that the women found at the clinics have been married an average of ten years, and are not as a body shirking maternity. They have managed a live birth oftener

than once in each three years of marriage; at most of the clinics, once in two and a half years.

No evidence by actual cases, from the clinics or from any other source, has been adduced to show that any physical harm has been done by contraceptives (except by one type which no clinic uses). (D-16, p. 7)

RELIGION OF PATIENTS

The religious beliefs of the European patients have not been recorded, although perhaps this has been begun in the Stopes Clinic. In America, according to the clinic reports, Protestants compose about one-third of the patients in New York No. 40, Los Angeles No. 57, and Chicago Nos. 50 and 51. The colored patients in Chicago No. 52 are of course practically all Protestants, and about one-half of the patients are Protestants in Newark No. 68, and Chicago No. 49. The Jews run from one-third in New York through one-sixth in Newark to one-seventh and one-tenth, and even less, in Chicago clinics. As Vienna is 97 per cent Catholic, most of the Ferchs' patients are Catholic.

The proportion of Catholics in American clinics is so large, and their presence is so important, that we have placed the exact figures in the accompanying Table II, "Comparative Ratios of Catholics and Irish-born Among Birth Control Clinic Patients and in General Population." It appears that the Catholics are patronizing the clinics in their proportion to the general population, and the Irish-born two-thirds as much, if one can judge from the small numbers of the latter represented. This comparative rate is pretty high for members of the race which in the old

country (Ireland) appears to practice contraception least of any in Europe.[1]

These facts confirm the view expressed by various European scientists (B-28) that the Catholics are taking to birth control just as surely as, but merely at a later date than, the Protestants among whom they live. Many Catholic regions show a birth-rate close to that of Protestant regions according to very recent reports by Professor Julius Wolf, of Berlin.

In Chapter VIII, however, we have pointed out that Ireland is a special case, slightly different from the rest of Catholic Europe, because she took to family limitation *by celibacy* very early and far more quickly than her Protestant neighbors, and is *very* slowly exchanging this for limitation by birth control. But we also suggest that immigration from Ireland is highly selective, those who stay behind being very exact in their conduct—highly celibate but when married highly fertile, with about the lowest illegitimacy rate in Europe, while those who come to the United States seem rather lax, their illegitimacy (U-1, p. 16) being very high, and their addiction to liquor

[1] Clinic figures are from official reports. As Catholic figures are available only by dioceses and not by the political units used in the census nor by the cities named, it was necessary to compute the general population figures by combining the census of the counties included in each diocese, according to the Catholic Yearbook. The figures for the counties are found in Volume III of the U. S. Census, in tables numbered "9" under each state. The "World Almanac" for 1921 stated that there were 1,273,291 Catholics in "N. Y.," meaning not the city of Greater New York, but the Catholic diocese of that name which omits Queens County and includes seven other counties and the Bahama Islands. As the latter have only 56,854 this makes little statistical difference.

The figures for Irish born are from Tables 11 and 13 in Vol. III, U. S. Census 1920.

quite marked according to some impressions. (O-3) Only natives, Russians and British-born in this country have smaller families. (U-1) We find from Table II that

TABLE II

COMPARATIVE RATIOS OF CATHOLICS AND IRISH BORN AMONG BIRTH CONTROL CLINIC PATIENTS AND IN GENERAL POPULATION, FOUR U. S. CITIES

From Official Reports of Clinics, U. S. Census, 1920, Catholic Official Yearbook 1920

City	Patients		In Corresponding Diocese		Per cent			
					Catholics		Irish Born	
	Total Clinics	Catholic	General Population Census 1920	Catholics Official Yearbook 1920	Clinics	General Population	Clinics	General Population
Grand Total	6,299	2,274	11,425,484	3,406,901	36	30	—	—
New York (No. 40)								
1925	1,655	434	3,910,023	1,273,291	26	33	2.8	3.6
1926	1,463	395	—	—	27	33	—	—
Chicago, Ill., B. C. L.								
(Nos. 49–52, 1924–26)	1,329	453	3,325,853	1,150,000	34	35	1.4	2.1
(Nos. 49–54, 1926–27)	1,536	906	—	—	59	35	—	—
Newark, N. J.								
(No. 68, 1928)	215	69	2,058,876	542,337	32	26	—	—
Cleveland, Ohio								
(No. 66, 1928)	101	17	2,130,732	441,273	17	21		

they are also probably taking to birth control more rapidly in the United States than at home.

These considerations about the Irish are important.

If true, they confirm the recent suspicions bruited in the United States that immigration to us is not usually representative of the parent nations as a whole, but may consist of special classes: in the case of the Irish, of an unrestrained class, albeit perhaps energetic and valuable. The Survey (S-27) quotes Dublin as declaring tuberculosis is twice as high among the Irish in America as among those in Ireland, and that this proves tuberculosis more environmental than hereditary. Ah, but does it? Are all these weak points brought out in Irishmen by merely migrating to a country of *better* living standards? Or is it a certain class only who have come?

Thompson, writing before the passage of the new Quota Law, says that the Celts and Mexicans constituted 40 per cent of our immigrants. (T-4)

LIMITATION METHODS FORMERLY USED BY CLIENTS

Practically, the work of the birth control movement consists in substituting better methods of limiting the size of the family for unsatisfactory or deplorable methods already in use. Without laboring the point to the extent of saying that the movement prevents conception of children destined later only to die, we may be very sure that the clinics substitute contraceptives with a great many individuals who would otherwise resort to abortion. Take the Jewish Center in Chicago: it has an unusual clientele, dealing as it does only with dependent families and making available its service only after considerable red tape and to the most appealing cases, though not withholding it from any regular clients who seek it voluntarily. Its list comprises 104 cases, some of whom may be described

as the least desirable element of the 325,000 Jews in Chicago. What, then, is found? *That 47 per cent are already practicing abortion.* (L-8) The goal of the social service nurse is to end these practices once and for all by means of many visits and patient education in the use of contraceptives prescribed and fitted by a reputable physician.

The medical estimate is that one half to nine tenths of all interruptions of pregnancy in the general population are voluntary, illegal acts. (F-3) (N-5) (D-8) This would seem to be borne out by figures from the New York center. Thus among 1,954 miscarriages reported in 1925 at the first visit 1,434 or 73 per cent, were admitted to have been illegally induced, as compared with only 520 therapeutic abortions.[2] This finding is also in harmony with the monumental work of Miss E. M. Elderton of the Galton Laboratory at the University of London. (E-4)

But abortion is not contraception.

The clinics also give better substitutes for the contraceptive methods in use by applicants. "Less than 10 per cent of the patients applying at our (New York) clinic state that they have used no contraceptive," says Dr. Hannah Stone. (S-20) In Newark it is less than 6 per cent. In Chicago 287 out of 400 stated what contracep-

[2] This single figure 520 for therapeutic abortions, was given in an unprinted manuscript part of the privately printed report. (S-21) We have also seen the printed statement by Margaret Sanger that such was the proportion found.

Students will wish to follow the results of the study now being undertaken by the N. Y. Academy of Medicine in coöperation with other medical groups, of the history of every woman reported dead from causes associated with maternity.

tives they had used, the rest stating no method or going unrecorded. (Y-1) In "Middletown," however, of seventy-seven workers' wives less than half knew of any method. (L-9)

The various methods of contraception in popular use have been summarized by Dr. Dickinson who made a chart showing the order of popularity of the different methods, securing the figures from Dr. Katharine B. Davis' study of 730 educated American women, from Dr. Bocker's 1,208 clinic patients, and from the recommendations of 64 obstetricians and gynecologists of New York and Chicago. (D-14) As this is not a medical work, it would not be proper to reprint Dr. Dickinson's succinct eight-line summary, but we may say that it shows the lay persons depending mainly on a method which all but four per cent of the doctors condemn, most of them with great force.

Dr. Stopes says that 1,284 of her 4,834 patients had previously used contraceptives, a list of which she gives. (S-24) It appears that her English lay people in 814 cases out of the 1,284 or 64 per cent, depended before coming to her on the method condemned by nearly all of Dickinson's physicians. About 200 more cases depended on these physicians' favorite method, and about a hundred others on a certain disinfectant.

Both Dickinson and Stopes proceed to a lengthy discussion, with statistics, as to how certain or uncertain in preventing conception these and a number of other methods have proved. Also, their advantages and disadvantages are discussed.

RESULTS, SUCCESSFUL AND UNSUCCESSFUL

As detailed in the preceding chapter, certain clinics have a better hold on their patients than is common in outpatient work. Nevertheless, in many cases the result of the treatment is not known.

Early in the movement some hasty conclusions were drawn that cases which were never heard from again were successful. (S-24) (B-29) It is more likely that the contrary is true, or most likely, as we show below, that the patients have abandoned the method. A woman knows instinctively that a complaint from her would be met by inquiry as to whether she was careful enough in using the method. In other connections, most persons are apt when discarding a new invention or service as "no good," to refrain from any discussion as to whether or not they have applied it correctly.

Table III "Disposition of Cases and General Results Reported by Three Birth Control Centers" gives the figures reported on failures and successes by the only organizations giving these items in any detail or using comparable methods to get them. These are special clinics: the Medical Centers of the Illinois Birth Control League (Nos. 49 to 54) (C-8, p. 207), the Clinical Research Bureau in New York (No. 40) (S-22), and the Mothers Clinic in Los Angeles. (No. 57) (C-8, p. 213)

To get an answer to the apparently simple question: "What is your proportion of failures?" requires the setting down of fourteen items in each case; beginning with total applications, and accounting for those not reported upon, reported upon, the use or non-use of the method, success or failure with use and a distinction made between various sorts of non-success.

Chicago and New York alike account for the use of the method, but

TABLE III

DISPOSITION OF CASES AND GENERAL RESULTS REPORTED BY THREE BIRTH CONTROL CENTERS

Applications, Admissions and Reports from 5,918 Patients

	Total		I. B. C. L. Chicago Three Years 1924–1927		No. 40 New York One Year 1925		No. 57 Los Angeles 31 Months 1925–1927	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
1. Total applications	5,918	100	2,763	100	1,655	100	1,500	100
2. Not advised	763	13	475	16	198	13	90	6
3. Advised	5,167(a)	100	2,288	100	1,469(a)	100	1,410	100
4. Not reported	1,615	31	926	41	336	23	353	24
5. Reported	3,552	100	1,362	100	1,133	100	1,057	100
6. Prescription not followed	(449)	(12)	275	20	174	15	—	—
7. Prescriptions followed, carefully or not	(3,103)	(100)	1,087	100	959	100	—	—
8. Successful	2,794	90	968	89	916	95.6	910	86
9. Not certainly successful	309	10	119	11	43	4.4	147	14
10. Pregnancies	301	—	119	11	35	3.5	147	14
11. Instructions not followed	—	—	61	5	18(b)	1.6	—	—
12. Instructions not followed, perhaps	—	—	38	4	11(b)	1.2	—	—
13. Instructions apparently followed	—	—	20	2	6(b)	.7	—	—
14. Doubtful results	—	—	—	—	8	.9	—	—

(a) Includes 12 cases in which same patient was given two different prescriptions during year, in a series in which method, not individual was unit.

(b) Estimated on proportions given for Chicago Clinics.

Chicago gives extra details about how instructions had been followed by women who became pregnant, while New York distinguished between definite failures, and those cases where the result was doubtful. The latter include such conditions as an apparent abortion reported after advice was given, which might have followed a non-recognized conception before the clinic visit, or which might have been simply an unusual menstrual flow.

In the Table these variations are allowed for by distributing the 35 New York failures according to the Chicago ratio, under items 11–13.

The Los Angeles report failed to give any notes on the use of the method, or the following of instructions. Thus the method cannot be blamed for all the 147 pregnancies.

Among the 5,918 total applicants, 13 per cent were not advised, for various reasons; in New York usually because there was no "medical indication," in the other clinics, more often because of existing pregnancy. In New York the 13 per cent not advised were those rejected by the physician, for the obviously ineligible are turned back at the admission desk, and not counted. Altogether one applicant in three in New York is not advised.

In New York 15 per cent and in Chicago 20 per cent of those reporting abandoned the method or never used it, either because of inconvenience, uncertainty, or because their condition changed through widowhood, or they decided to have children. In North Kensington non-use was about the same (H-4). Los Angeles, probably because it does not account for the cases of non-use or of carelessness, has a high proportion of apparent failures, 14 per cent, and in a later report (1929) states that one hundred pregnancies have occurred among 500 clients under care for two years each.

In the New York Center, the 916 successes shown in Table III were for the following periods (S-22):

Under six months	153
Six months to a year	323
One to two years	393
Two years and over	47

This "time-table" does not show the per cents of successes on totals of the same space of time, but on page 14 Dr. Stone gives the period elapsed before 35 definite failures, and it is shown that the majority actually and proportionally occurred before six months.

Because of the uneven reporting, the variations in time, and even more because of the peculiarly difficult class of people attending the Los Angeles Clinic, comparisons would be invidious. A great difficulty with these statistics is that the period during which pregnancy was prevented was not stated; or else very few in the totals have carried on more than a year. It is only the great importance of the matter which has led the Chicago and Los Angeles centers to publish, almost against their will, these tentative figures. With all its deficiencies, Table III has been printed as a sample of methods of accounting so far as developed.

Importance of the Cases Not Reported

It has been realized for some time that the unreported cases are the stumbling block which prevents the physician from knowing fully the measure of his success. These cases are also tied up with the chief moral hazard in birth control. For one of the main points made against birth control by its few opponents at the annual 1922 meeting of the Holland economists—which was devoted wholly to the population question—and by the chief of the Holland census, was that people with whom contraceptives had failed were then more than ever tempted to resort to abortion. (B-7) (M-20) Plainly, after so doing, they might be unlikely to report again to a clinic.

Some data on this danger of increased temptation to abortion comes from Kahn's so-called municipal clinic in New York (K-1) and from Katharine B. Davis. (D-5) Dr. Kahn thinks he has proved that people knowing contraception use abortion less than those ignorant of it. I think his figures are open to another interpretation. The real distinction is between people less driven to either device and people of greater fertility more driven to both. Dr. Davis' study showed this, as regards contraception.

The Unreported Cases compose about one quarter of all cases advised in New York and Los Angeles; two fifths in Chicago. (Table III) In New York they usually employ field-workers to go after those not reporting. In Los Angeles they seek the aid of the general social workers. Dr. Cooper emphasizes what slow work this is in New York: out

of 688 not reporting by mail, 357 were visited, being within a reasonable geographic area, known to be still living, etc. but of these only 109 were found at home and willing to talk. (C-8, p. 191) What did they say? Two thirds said "not using." The statistician is at a complete loss how to regard this figure, or that of the unknown number "unwilling to talk." These groups may contain nothing sinister. On the other hand, they may conceal most of those who became pregnant and afterwards secured abortion. We must realize that the women perhaps hesitated to say the method failed for fear the next question from the visitor would be, "Well, did you have an abortion?" Or that they vexedly dismissed the whole inquiry through the same anger or fear that may have made them neglect the mail inquiry. Of course all this fails to apply to those who were not at home or had died, but only to those "unwilling to talk," or claiming that they were "not using."

Mrs. Benjamin Carpenter agrees with us that these field inquiries should be abandoned, except among illiterate women. A great expense is involved. Also, on account of the uselessness of ascertaining merely that a woman is dead, without knowing the cause (for instance, she might have died in pregnancy or labor) and on account of the danger of "loading" the figures with cheerful answers to the field worker from the successful cases, and of getting only an "unwilling to talk" where pregnancy and abortion have occurred, I think one feels more confidence in figures made up only from mail reports, supplemented of course with field visits to illiterate women. *The illiterate should, for every eugenic, medical and statistical reason, be on the field worker's visiting list from the first moment.* All patients will, then, have to be classed at the time the case is entered, as able or not able to fill out a blank.

The mail inquiries should be made as easy to answer as possible, an addressed postal being enclosed, numbered, and not needing to be signed but simply marked. Such an inquiry should be framed with great care to elicit the one thing we want to know, "Have you become pregnant against your will while using our method?" After this, if a woman continues her reluctance or refusal to answer, a visit is not certain of eliciting the truth.

MAXIMUM FAILURE POSSIBLE AT NEW YORK CLINIC—AN ESTIMATE

Since we have felt such concern over results among unreported cases, it is a great satisfaction to note that a

possible maximum of 16 per cent failures is all I can estimate, *at worst*, from the New York figures. Probably the reality is much nearer the 4 per cent undoubtedly gotten on the reported cases alone.

Analysis. Table III shows that of the 959 patients who reported that they had followed prescription, whether carefully or not, only 43 reported non-success, or 4.4 per cent.

It remains to estimate the possible maximum of pregnancies among the unreported cases, numbering 336.

These 336 who failed to report and were not visited may be divided into two categories:

(a) those who if visited at the given address would have been found and willing to talk

(b) all the rest, who if sought would have been either unwilling to talk or not found because dead or removed, etc.

We know from the experience of New York and North Kensington (Chapter II), that if the 336 had been thus visited, one-third would have been in category (a) and two-thirds in category (b). One-third of 336 is 112, two-thirds is 224.

Of the 112 cases called (a), the sample shows that only one-third (37) would have claimed to use the method and these may be supposed to have had no worse luck than the reporting cases. If so, 4.4 per cent would have had pregnancies or less than 2 actual pregnancies among them. Of the 75 claiming not to use it, we can estimate half or 38 as really using it, but becoming pregnant, nevertheless.

The remaining 224 cases of category (b) are the suspicious ones, in so far as they were "unwilling to talk." *For an estimate of maximum failure*, we may subtract from the total of cases to be considered all who were dead, divorced, or had decided to have children although the method was proving successful, and those who from the beginning had never tried the method. It seems safe to assume that one tenth were dead, another tenth never used the method, or were desirous of children. That is, we may reduce the 224 (b) cases, by 45 cases, to 179 and if we assume that a third of these had moved and subtract them, we have 122 for whom the pregnancies must be estimated. (S-22, p. 9) To be on the safe side, let us suppose all the 122 became pregnant.

We have, then, a total of 205 pregnancies as follows:

122 among 179 (b) cases
40 among 112 (a) cases
43 among 959 originally reported cases.

This total maximum estimate of 205 pregnancies among 1,250 cases who had continuously used the method, gives a rate of *not more* than 16 per cent possible failure on both reported and unreported cases. This compares fairly with the figure given in the 1929 report of Los Angeles No. 57.

This exact estimate of the maximum of possible failure is very welcome and reassuring. When I was in London, doubts were expressed to me concerning the amount of success obtained with the methods. I was advised to seek the opinion of a well known person—Miss Ann Martin. I went to her tiny house far down by the docks, where she has done settlement work for half a century. I asked why they had sent me to her. She said, "Because it was my women from this neighborhood whom I brought in considerable numbers to their first great meeting for Walworth, who made a great part of the audience, and who have contributed to their patients since." I said, "What have you to say?"—She was so burdened with the years that she had to save her voice, but she said, "Well, my women tell me the trouble is, the clinic method doesn't work." She gave me her pamphlet on family limitation, which shows by its vigor what an important help she must have been, as has been intimated, in the early stages of the movement.

It is indeed probable that no contraceptive has been yet found that will not fail at times, especially when the

user is careless. But many scientists are optimistic of discovering more certain, not to say more nearly foolproof, means or devices.

It is often urged against contraception that it "does not work" with any certainty. But take an analogy. Shall one say that sanitariums for tuberculosis are worthless because they "do not work" with certainty? So indeed might certain socialists argue who oppose sanitariums as being deliberate substitutes for a living wage. But other thinkers support them as palliatives for people already tubercular. Similarly, we are faced with a "condition and not a theory" concerning control of conception. Contraception having failed, a few parents no doubt then receive their first impulse towards the destruction of the fetus. But many people in the same group are already settled in their determination to make away during the very early months with all inconvenient conceptions. As shown later in this chapter, it is probable that ten per cent of all conceptions end in this way. Thus, if contraceptive practice tends to instigate a few crimes, it also tends to prevent a great number.

It should be further noted concerning abortion that it is often committed illegally and surreptitiously when the case really would justify its being legally arranged for, on the score of saving life or health. As light is let in on all this subject, these unnecessary illegalities will decline. Needless to say, unnecessary loss of women's lives will also decline.

GROSS VERSUS NET FERTILITY

The only items that appear on all the case sheets, except at No. 60, are those dealing with the effectiveness of

the woman's reproduction—that is, how many pregnancies she has had, and the results of each. Thus, there is a mass of 60,000 case histories, a mine of prenatal statistics particularly, in some respects more complete than any others in the world if it is true that the patients are likely to admit past abortions, though often illegal, more freely to the sympathetic ears of the birth control enthusiasts than to others. However, the clinic records do not tell the whole story, even if complete. A maternity hospital which may handle most of a town's deliveries, obtains more highly representative histories than any birth control clinic. One reason for this is that the clinic figures never can include the ill-fated offspring of women dead from pregnancy or from other causes.

Dr. Stopes and Mr. Himes, the leading non-medical writers, have been interested to show what a great waste there is revealed by birth control clinic records between the many initial pregnancies of a fecund woman and the resulting family of children. (S-24) (H-3) (H-4) But the waste is, in reality, probably much greater than they succeeded in uncovering.

Herewith is the M. C. Stopes' table on pregnancies and losses reported by the first five thousand women attending her clinic. (S-24) This showing of a wastage rising to fifty *per hundred*, whereas ordinary mortality rates are usually less than that when reckoned *per thousand*, has been very valuable in drawing public attention to the situation, for physicians have not bothered to popularize the news of the still higher rates which they have found.

On the other hand, this Stopes table is doing harm among would-be statisticians wherever it is taken as a model. It is cast in the wrong form at several points,

MOTHERS' CLINIC

Preliminary Survey of 5,000 Cases attending the above up to 31 August, 1924

The maternal histories of the 4,235 mothers whose pregnancies occurred before coming to us

Pregnancies			Live children		Deaths		Miscarriages		Total disasters	
Number	Cases	Total	Total	Per cent	Total	Per cent	Total	Per cent	Deaths—and fœtal *in utero*	Per cent of pregnancies
Once pregnant.....	887	887	834	94.02						
Twice pregnant.....	1,088	2,176	1,982	91.08	289	5.01	271	4.82	560	9.83
3 times pregnant...	787	2,361	2,048	86.69						
4 "	535	2,140	1,756	82.06	146	6.82	238	11.12	384	17.94
5 "	335	1,675	1,312	78.33	124	7.35	239	14.32	363	21.67
6 "	203	1,218	949	77.91	106	8.69	163	13.40	269	22.29
7 "	136	952	691	72.58	93	9.77	168	17.65	261	27.42
8 "	100	800	592	74.00	103	12.90	105	13.10	208	26.00
9 "	56	504	359	71.23	59	11.70	86	17.07	145	28.77
10 "	44	440	294	66.82	69	15.69	77	17.49	146	33.18
11 "	24	264	190	71.99	22	8.33	52	19.68	74	28.01
12 "	22	264	166	62.91	49	18.55	49	18.55	98	37.10
13 "	5	65	42	63.84	11	16.90	12	19.25	23	36.15
14 "	5	70	50	71.43	8	11.43	12	17.14	20	28.57
15 "	5	75	45	60.00	22	29.33	8	10.67	30	40.00
16 "	1	16	12	75.00	2	12.50	2	12.50	4	25.00[1]
17 "	2	34	17	50.00	10	29.41	7	20.59	17	50.00

[1] This one remarkably healthy family brings down the death-rate, but even so it is high.

Note that the above figures are reckoned *per hundred:* ordinary census death-rates are *per thousand.*

THE "STOPES TABLE" ON PREGNANCIES AND WASTE

Reprinted exactly from "The First Five Thousand," by Dr. Marie Stopes (S-24)

and especially for showing, as Dr. Stopes claims it shows, that increasing wastage is caused by an increasing number of pregnancies. (S-24) Some such correlation has indeed been found, as we shall see, by others, but Dr. Stopes' form of table merely *seems* to prove it. For this purpose her table is very much confused: 1) by the uncertainty as to how twins and triplets with their heavy mortality were treated; and 2) by the fact that the high mortality shown toward the bottom of the table is really made up from the fate of early pregnancies as well as later pregnancies in those large families; and 3) by the possibility that the low mortality rates at the top of the table are low not only because the mothers were not depleted by many pregnancies, but because they were healthy, high-class women; and, correspondingly, the rates in the bulk of the table are high, perhaps *only* because they deal too largely with poor, careless, uncleanly people. In other words, the effect of order of pregnancy in the Stopes table is concealed among numerous other factors.

Moreover, because the whole array of the Stopes losses by miscarriage are only one third complete according to medical opinion, two thirds of the miscarriages never having been reported, the material is poor for working out delicate causal factors.

Only the future can show how all the other clinics will eventually treat their similar data. In Table IV, I have collected together all the figures on pregnancies and results that they have so far put out, under the head "Net Fertility of Women Attending Birth Control Clinics." When seen thus all together, they throw light on each other, and it becomes easy to criticise them in the hope that the clinics may in future, first, improve their ques-

TABLE IV

NET FERTILITY OF WOMEN ATTENDING BIRTH CONTROL CLINICS. PREGNANCIES AND RESULTS REPORTED BY 13,005 WOMEN IN FIFTEEN CLINICS

Clinic, Serial No. from Table I and Reference	Part 1. Numbers of Mothers, Living Children, Dead Children, Live Births, Prenatal Losses						Part 2. Averages: Ages, Years Married, Surviving Children, Live Births, and Total Pregnancies per Mother; Losses, Prenatal and Later per 1,000 Live Births								
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
		Children					Per Mother						Per 1,000 Live Births		
							Average						Losses		
	Mothers Reporting	Living on Date of Report	Dead in Infancy or Later	Live Births	Prenatal Losses	Total Reported Pregnancies	Age	Years Married	Children Living	Live Births	Total Pregnancies	Total Losses (Column 11 minus 9)	Prenatal	Later Deaths	Total
Total	13,005	36,827	5,000	40,973	7,924	49,996(a)	31	10	2.8	3.2	3.8(b)	1.0	193	122	315
40 New York, 1925	1,655	3,703	482	4,185	1,954	6,139	—	—	2.2	2.5	3.7	1.5	467	115	582
40 New York, 1926	1,463	3,519	490	4,009	1,065	5,074	—	—	2.4	2.8	3.5	1.1	266	122	388
26 Stopes (S-24)	4,235	11,339	1,113	12,452	1,489	13,941	—	—	2.7	2.8	3.3	.6	120	89	209
35 Birmingham, early (H-3)	165	479	71	550	59	609	32	10	2.9	3.3	3.7	.8	107	129	236
35 Birmingham, 1927 (E-8)	569	1,747	159	1,906	313	2,219	—	—	3.1	3.4	3.9	.8	164	83	247
29 Wolverhampton (H-3)	498	1,450	198	1,648	140	1,788	31	8	2.9	3.3	3.6	.7	85	120	205
32 Manchester, early (B-20)	423	1,265	157	1,422	230	1,652	—	—	3.0	3.4	3.9	.9	162	110	272
32 Manchester, later (H-3)	600	1,783	288	2,071	260	2,331	31	9	3.0	3.5	3.9	.9	126	139	265
28 No. Kensington (H-3)	1,000	3,005	426	3,431	460	3,891	31	9	3.0	3.4	3.9	.9	134	124	258
31 Cambridge (H-3)	309	1,014	107	1,121	91	1,212	32	10	3.3	3.6	4.0	.7	81	95	176
— Dr. Kahn's (K-1)	464	1,517	557	2,074	646	2,720	—	16	3.3	4.5	5.9	1.9	302	269	571
— Cannock Miners (H-3)	114	386	—	—	—	465	—	9	3.4	—	4.1	.7	—	—	—
33 Glasgow (H-3)	150	520	106	626	73	699	31	10	3.5	4.2	4.6	1.1	117	169	286
57 Los Angeles (L-4)	314	1,075	155	1,230	355	1,585	—	—	3.5	3.9	5.0	1.5	291	127	418
9 Frankfurt (R-4)	600	2,160	402	2,562	660	3,222	—	—	3.6	4.3	5.4	1.8	258	157	415
37 Liverpool (H-3)	234	911	196	1,107	88	1,195	32	10	3.9	4.7	5.1	1.2	80	177	257
36 Aberdeen (H-3)	109	486	93	579	41	620	31	10	4.5	5.3	5.7	1.2	71	161	232
55 Chicago Jewish (L-8)	103	468	—	—	—	634	—	—	4.7	—	6.2	1.5	—	—	—

(a) Includes figures for Glasgow (No. 33) and No. 55. Not given separately in columns 4 and 5.

(b) By omitting the figures for the first three (pioneer) clinics, it may be calculated that the mothers in the remaining and more typical centers had 4.4 pregnancies apiece. In other words the average as it stands is weighted in the direction of the earlier figures.

tionnaires, and second, forbear to fall into the errors of tabulation just described.

GOOD FERTILITY BUT NOT MORTALITY RATES

Table IV gives data on pregnancies and net results from fifteen clinics.[3] Columns 9 and 10 on fertility are of use to us but the other columns on mortality are of small scientific value.

It may be noted for comparison that 822 educated women had only 2.74 pregnancies each, and had such large pre-natal losses that their children born alive were very few indeed, 2.1 each. (D-5)

Of course, however, we must realize that the clinic figures have been collected to serve another purpose than science; namely, legitimate propaganda. It was necessary to show the public what a burden of illness and crime there was waiting to be obviated by birth control. The *higher* medical figures, which show this even better, have not been generally available, and if they had been, they would not have been believed by some of the public. If in the future these clinic mortality figures are offered to the public, it should be with the explanation that medical figures for prenatal losses usually run far higher; that, therefore, the "wastage" total is really far greater. The "wastage" shown in Table IV, by dividing any *total loss*

[3] Table IV is derived from many sources. Some of the items for each clinic had to be computed entirely afresh. Wherever possible source figures for the component parts were used, as for example number of living children, deaths, or prenatal losses, and the figures for total pregnancies were made to conform. Thus, mainly because of discrepancies in decimal adjustments the totals do not always correspond to the figures originally published for that item.

average (column 12) by the corresponding pregnancy average (column 11), ranges from 15 per cent to 39 per cent, whereas medical figures (see below) give an average of prenatal losses equal to 30 per cent before any postnatal mortality is added in at all.

Let us find out what ails the mortality figures as collected at present at the clinics. To do so, we must consider absolutely apart the children's deaths and the prenatal losses. It will be well also to bear in mind just how far human science has gotten as yet with studying these two kinds of mortality rates: children's mortality rates are well known by year of age, though not by social class; prenatal mortality is little known in any way. Therefore, any data at all on the latter one hopes will be useful, but only very particular data on the children's mortality are likely to be worth taking.

PRENATAL DATA

In this field of statistics the clinics' chief competitors are the physicians working on similar individual histories obtained in maternity hospitals (W-4) (P-1), and on estimates of total abortions judged from the complicated cases that end up in the hospitals after the illegal practitioners have made a bad beginning with the patient. In Chapter VII will be found a number of estimates by medical men which seem to establish this minimum: *prenatal losses are at least ten per cent of the pregnancies.*

But if we wish actual figures we may apply to the authority Dr. J. B. DeLee, as did Dr. Douglas P. Murphy for his very important paper (M-29) on the dangers in ovarian irradiation and receive the verdict that to get near the truth one must go to Germany!

Dr. DeLee collected a series of observations by five men in Vienna, Berlin and Hamburg made between the years 1898 and 1920 showing that the abortions (all prenatal losses before viability) varied from 19 to 57 per cent of all known pregnancies. This gives a simple average of 33 which in the absence of the base figures is the nearest one can come. The percentages observed run as follows:

	per cent
Latzke, 1898, Vienna	19
Latzke, 1908, Vienna	33

	per cent
Latzke, 1913, Vienna	57
Bumm, 1917, Berlin	20
M. Hirsch, Berlin	30
Schottelius, 1919, Hamburg	50
v. Jaschke, 1920	25

Recent evidence from Russia is also important. (V-2) (L-7) In that country, induced abortions are no longer crimes, nor illegal if performed by qualified practitioners. Hence, women report them more freely. Similar figures to the average in the list quoted are obtained. Lubinsky shows that in Leningrad a very great increase in abortions, as *registered* under the new law, has coincided with a birth-rate higher than before in the city and an annual increase of European Russian population one-third faster than in 1913. (L-7) Hence one argues that these high abortion rates are normal; were always thus high, though formerly concealed.

It is, however, possible that actual abortion rates are consistently higher in these non-colonizing nations than in England and our own country. See Chapter VII. Crew of Edinburgh gives 16 per cent to 20 per cent as the abortion rate on all pregnancies. (P-16, p. 224)

Viewing Table IV in the light of these figures it appears that the clinics, especially the English, have had no particular success in getting confessions of prenatal mortality from their client-mothers. The English specify that they did not seek such success. Remembering that 10 per cent to 33.4 per cent of the pregnancies equals mathematically 11 per cent to 50 per cent of live births, we see from column 13, Table IV, that nearly half the English clinics' prenatal mortality rates are below the medical *minimum* estimates and none even of the higher English rates reach one-third of the way to the average German and Russian figures. It appears that the English respect for the citizen, however poor, and English reluctance to pry too much into private affairs have probably made it quite useless for them to ask the prenatal questions. The other clinic rates get half way to the German and Russian average, except the first New York rate which gets practically all the way there. This is doubly surprising because the Jews, the race least given to stillbirths (W-9, p. 171), composed one-third of the New York patients.

Why did this one clinic obtain so many more acknowledgments than any other? Note that it is in the first year or so alone and that, according to Mrs. Sanger, 73 per cent of them were induced. After that about the same acknowledgments were obtained as in any other non-English clinic. Three suppositions, not mutually exclusive, are possible: 1)

in the first year the data are inaccurate; (however, Dr. Hannah Stone rechecked the replies in the inner office); or 2) the questions were asked with a particular zeal and tenderness by that particular type of earnest worker whom Margaret Sanger knows how to enlist; or else 3) the clients of the early year were twice as much addicted to abortion as were the clients everywhere else and as were the clients of the succeeding year at the same clinic. The succeeding year in the press of work and with an increasing, changing, and less trained and zealous office personnel, the interrogations were much less persuasive; or else, as we said, it must be supposed that the clientele changed tremendously during a short time. To be sure, every new highly advertised clinic gets a lot of "bad" cases at first, and the legal and other conditions were very peculiar in New York at that time. Is it the explanation that the clients were unusual, or must the high rate of abortions confessed remain as a goal to show what tactful questioning can elicit?

Suspicion of all these low prenatal rates of column 13, Table IV, except the first New York figure, is increased by the fact that column 13's correlation with column 10 for live births is small and *negative* (r equals $-.32$) and with column 11 there is absolutely no correlation. It is scarcely credible that the groups with the fewest children born should have had the most abortions. But it is of course possible; it may be that the small-family groups are so because of the abortions committed. So much for abortions and net fertility, but what about abortions and pregnancies? How explain pregnancies twice as numerous at the bottom of their column, but no general increase in the prenatal losses? Moreover, we have the important study of Parkes, the well known physiologist of the University of London on 10,043 cases, who says: "The somewhat remarkable conclusion is reached . . . that the parity (number of times a woman has been pregnant) controls the amount of abortion, and the age of the mother the amount of stillbirth." (P-1, p. 588.) To the last phrase about stillbirths Neale of New Zealand assents, but Westergaard sees other important factors as well. (N-2) (W-1) It seems, then, that the rate of prenatal losses, with which stillbirths should be included, ought to rise with increasing family and increasing pregnancies. It casts suspicion on the clinic figures when they fail, as in Table IV, to do so. It appears the figures are incorrect because the patients failed to confess the abortions.

The whole matter is intriguing. Is the parity, as Parkes says, the overmastering controlling influence over the number of abortions (at least prior to seven months), so much so that it conceals all other influences until it is isolated? Or is the controlling influence the number

of surviving family? It is possible that the influence is a voluntary one working out through illegal abortion, though Parkes seems innocent of this explanation.

DATA ON CHILDREN'S DEATHS

The clinics have been asking each mother how many children she has lost between their birth and this day of her visit to the clinic. This question gives case-worker and physician a vision of what her life has been, but statistically it is of no use except for propaganda on "wastage" as described above. To calculate any mortality rates or to bore into causal factors as described in the next section, one must know at what age each child died. The case-sheet might at least indicate the infant deaths if not the ages of all children at death.[4]

CORRECT METHOD OF SHOWING EFFECT OF REPEATED PREGNANCIES

As Dr. Stopes (S-24) has strongly intimated, the clinics' chief statistical effort should be put upon this very important question of determining to what cost the average mother, and the whole of human society, is put by the strain of repeated pregnancies.

At first glance a table such as Dr. Stopes' above seems to say that the mortality rates mount steadily. But we have spent several paragraphs in showing that the low rates in her table *may* be too low; and also the high rates may be high perhaps *only* because they were made up almost solely from poor people's often under-nourished and ill-protected offspring. Hence no real mounting of rates caused by mounting pregnacy has yet been proved.

A different and more refined tabulation is necessary to eliminate these suspicions. It is absolutely essential that all tabulation be by order of birth of the child and not by number of pregnancies in the

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[4] Note that column 14 in Table IV is calculated on "total live births," a far less shifting base than that of "total pregnancies" used by Dr. Stopes. After one finds (col. 13) that one clinic reported nearly six times as many prenatal losses as another, one ceases to feel that "total reported pregnancies" is a sufficiently stable base for children's rates. But also note that column 14, and also its high correlation (plus .76) with column 10, all mean nothing at all—because it is not a column of real mortality rates on the same age throughout.

mother. What one wants to know is: does an advanced *order of birth* entail risk to the *child*? One is not inquiring whether the mother's quality as being the kind of woman who lets herself get continually pregnant entails the probability that she is also the kind who can't prevent her offspring from dying. The very statement of the latter proposition (thus carefully) shows that it is what the eugenicists are interested in proving, while the former is what interests the birth control student. Or it may be stated thus: in the Stopes figures, the mortality of the poorer class or "big family" first children is not shown, but only the mortality of all first children, among whom "big family" first children are lost in the crowd. The mortality of first children in families which are eventually to have many children may approach near to the high mortality already discovered for "latter" children who are only found *as a rule* among this certain class.

It is to be feared that the clinics have often failed to query the parity (order of issue) of each child or foetus. But supposing it has been noted, each order of issue must then have its mortality studied by special methods to isolate such other causal factors as mother's advanced age and low income, and also "social status," supposing any criterion other than income is found workable, from the factors of "too numerous pregnancies" and "too closely spaced pregnancies," which are our special interest. Such methods will be found in detail in the highly significant works of Dr. Robert M. Woodbury, in which, using the Westergaard method of expected cases, he has bored deeper into infant mortality than has any other scholar. (W-9) (W-10) (W-1) Dr. Woodbury's work seems to be the main hope for those opposing the Galtonians who believe heredity is the overpowering determinant in infant mortality. This debate is likely to remain active for some time and it is well worth while furnishing ammunition for either side.

A too simple method of trying to sort the factors is to compare the death-rates of the first three children in large families with the death-rates of the seventh, eighth, and ninth *in the very same families*. This does not allow for the facts that the mother was older when she bore the latter three, and that the same family income which provided for three may not have provided for nine sufficiently. This influence of income it is desirable to separate out if the state by public education or otherwise, or the industry employing the father (as in France), or private charity or the Church expects to help raise some of the children. But if it is felt absolutely necessary that every pair should be made to bring up their own children, including the payment of adequate taxes to the school system, then and then only, there may be no need to take

the trouble of separating income effects from physiological effects of repeated pregnancies.

PREVIOUS STUDIES OF THIS SORT

Lucien March, the head of the French census, has shown that latter children die more than earlier children. (M-6) Those surviving even to "ages over forty-five years" still show the tendency. But he points out that it may very likely be because "latter" children (i.e., of high order of birth) come largely from the poorer classes.

It is, as we have said, Dr. Woodbury who has succeeded in coping with this suspicion, and after eliminating the factor of wage and other factors, has shown that the infant mortality which is due to an order of birth has perhaps a range represented by figures 90 to 130. (W-10, p. 68).

These particular studies of Woodbury and March consider only the fate of live births. Dr. Woodbury (W-9) and Miss Rochester (R-6, p. 136) have extended their studies to the stillbirths, with their fate tabulated by order of birth, but separately from the live births. Parkes, on the contrary, considers only the stillbirths *and* miscarriages with no live births. (P-1).

Dr. Hamburger's figures are the only "all over" ones I have seen, aside from Dr. Stopes.' He too, gives in one table the fate of 5,962 conceptions in 1,042 Berlin workmen's marriages tabulated by size of family. (B-35) But unlike Dr. Stopes, he reckons the mortality up to an exact age in all cases; i.e., the seventeenth year. Whether he also improved on her method by dealing only with completed families, I do not know. His families, being all workmen's families, were far larger than hers, and his average mortality on them all far higher (equal to the highest in Table IV). Note that his tabulation being, like hers, by size of family must not be taken as a model by clinics trying to demonstrate the physical effect of repeated pregnancies.

I am told that Japan and the Netherlands publish statistics of losses from the fourth month of pregnancy on, which are less incomplete than other government figures. Most government prenatal figures run a mortality around three per cent of all issue (reported pregnancies), whereas the real rate is nearer thirty per cent.

SUGGESTIONS FOR HANDLING THESE DATA

The subject of prenatal mortality is of such interest and importance that I believe the clinics ought to push on with their investigation, in

spite of all difficulties. The data are flowing in at the rate of at least 12,000 families, or 60,000 individual offspring yearly, and are very detailed. One cannot but believe that a qualified actuary or other expert such as Dr. Woodbury, could, if put in charge, develop some very definite mortality rates for the early months and years after conception. Such an extension of the Life Table backwards towards its logical starting-point at conception is highly desirable, especially from these data, which could also be developed to give the correlations concerning age, income class, etc.

The first necessity would be to improve the reporting of prenatal losses. Experiment might be made with having these reports made anonymously by dropping slips in a shakable locked glass bowl. Or it may be possible to secure a great increase in the abortion reports as soon as the questioners fully understand that, if German and Russian figures are right, then they should secure half as many reports of prenatal losses as of live births. Or it might be desirable to proceed by the usual method of constructing Life Tables: let a group of clinics, coöperating for one year in a special study, concentrate on securing the exact number of pregnancies with result in life or death and at what age before or after birth, during a recent calendar year. Theoretically, this should give perfect results, except insofar as clinic mothers are not representative of all mothers, or were not accurate about even one year's experience.

The second necessity is to get clearly in mind that "number of pregnancies" can never be known, but only the total reported issue, composed of the sum of "live births," "stillbirths, and abortions, spontaneous and induced," with the last very difficult to get right. Dr. Parkes says "the real amount of prenatal mortality is quite unassessable owing to the great amount occurring in the first three months of pregnancy without any indication of the true state of affairs. This early mortality, which results only in absorption of the foetuses or profuse menstruation, has been calculated by Pearson to amount to more than all the rest of the uterine mortality." (P-1, p. 578) (Some people, however, consider this "calculation" to have been based on hypothesis.) Any mere statement from a woman that she was pregnant a certain number of times is valueless because if a woman cannot remember how the pregnancy turned out, she cannot get it correctly in the count at all. It is absolutely necessary to have a series of numbered spaces on the case-sheet, one for each occurrence as did Dr. Stopes. A highly educated woman has testified that the woman's *count* of even her perfectly certain misfortunes is very much confused by the uncertain memory of those

in which neither she nor her physician, if she had one, was sure whether or not a pregnancy and a loss had actually occurred. No Life Table can be worked out until the prenatal losses are given separately by periods of gestation, as:

(a) First to third month (inclusive)
(b) Fourth to seventh month
(c) Stillbirths, seventh to ninth

This is, I believe, the recommendation of a sub-committee of the New York Academy of Medicine.

The question remains whether these prenatal losses should be calculated as a fraction of "live" births only, as Table IV does,[5] following Newsholme's advice (N-7, p. 81) and Neale's (N-2), or whether they should be calculated as a fraction of the total risk; i.e., of the total of all reported issue including live births, stillbirths and spontaneous and induced abortions. The latter course is advisable according to logic and to the non-British authorities, Westergaard, Woodbury, Von Mayr, and the International Aperçu de la démographie, Institute International de Statistique.

It is possible that we have in prenatal losses, in their involuntary division, the most variable of all vital phenomena. Whereas the birth-rate is the resultant of a hundred influences and the death-rate likewise, we have here in illegal abortion perhaps the yet more variable link between them by which a balance is restored when births, or rather surviving children, begin too greatly to exceed deaths. Of course, as contraception increases the numerical importance of any such corrective link will decline.

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[5] At present, the clinic reports do not usually state where they have grouped the stillbirths, though in the majority of the entries in Table IV, we have reason to think they were put in the wrong place; namely, with children who died. This is from the standpoint of physiology. From other standpoints, however, it may have been the right practice, —namely, if stillbirths resemble infant mortality in being largely involuntary while abortions are in the majority of cases voluntary.

CHAPTER IV

ORGANIZED BIRTH CONTROL BECOMING EUGENIC

MANY persons oppose birth control because they believe it will have a tremendous effect in lowering the quality or the quantity of the population. In Chapters VIII and IX these great expectations are examined at length, especially the supposed menace of a differential birth-rate, and the conclusion is reached that they are akin to other early forebodings, such as that an automobile going fifteen miles an hour would kill all concerned, or that the use of anesthetics to relieve pain is contrary to God's plan for humanity. Extended study has not yet revealed what effect, if any, is to be made by birth control ideas and propaganda on either the quantity or the quality of population.

However, the tendency of the *clinic* work as distinct from general propaganda is definitely *eugenic*, as shown in this chapter. That is to say, a severe critic examining the eugenic effect of both words and deeds of the birth control partisans will find the deeds, i.e., the clinics, highly satisfactory, but the words, or the propaganda, less so—while the philosopher will doubt whether either is having any effect on such a complicated entity as the quality of population.

Finally, this chapter discusses how the clinics, and particularly the propaganda, might be made even more eugenic.

The complaint is heard at times that the clinics accelerate the differential in the birth-rate. So it is important to know what classes they reach. Evidence from nearly all the seventy clinics appears in Appendix A, together with an account of how this eugenic information is taken and *ought to be taken* on the case sheets to show the health, wealth, heredity, and social status of the clients.

SUMMARY OF THE STATISTICS

Fourteen sets of figures for fifteen clinics appear in Appendix A, in addition to nine statements received in such form as the following: The average wage at Birmingham (No. 35) was £2/5 s. (about eleven dollars) a week.

For eleven sets of figures, we are indebted to the important and patiently made research of Norman E. Himes, the Harvard scholar who, with his wife's assistance, investigated the English birth control movement with funds granted by the Social Science Research Council. (H-3) But the interpretation I draw differs from his. The remaining sets of figures are more largely my own, though generous thanks are due to Mr. Gosney and Dr. Paul Popenoe for lending a member of their staff for the clerical work at Los Angeles, whom they were able to spare from their comprehensive researches on eugenic sterilization. (G-3)

The occupational statistics are for two of the Illinois League clinics, for one in Baltimore, and for nine in England, all but one of which are under the Society for the Provision of Birth Control Clinics. Those with family income statistics are New York No. 40 and Newark No. 68, and wage statistics are given for Los Angeles No. 57.

The whole collection reveals for the first time what might have been suspected *à priori:* the clinic patients at these fifteen institutions especially established for birth control and nothing else, are naturally made up of all classes, but these are not in the same proportions as in the general population. In many of these clinics, the unskilled workers and the uppermost class are represented in undue proportions, but the artisan and middle classes are relatively deficient. The excess of the upper classes is only relative; in actual numbers it is tiny, except in the three pioneer clinics.

This usual state of things is shown in the accompanying figure, based on data from nine English clinics, as shown in Table VI, Appendix A. The classes below the ranks of skilled labor have a proportionate representation from two to three times as great as they have in the general population. This is the outstanding and significant fact that emerges from the British figures, as from some of the American. At Los Angeles the wage statistics are inconclusive but the staff is certain that a majority of their families are dependent and also they are very largely from the unskilled.

SUMMARY OF OTHER EVIDENCE

The statistical evidence is mostly from the special clinics. Other evidence of a non-statistical character is no less conclusive for the public and social welfare organizations. At twenty-six hospitals, health centers and so forth, the whole procedure tends to select clients and give assurance that nearly all are of low economic and social status. Thus in most California clinics no special

case-sheet is used, but merely the regular sheet used in common by the local health agencies, which is unusually

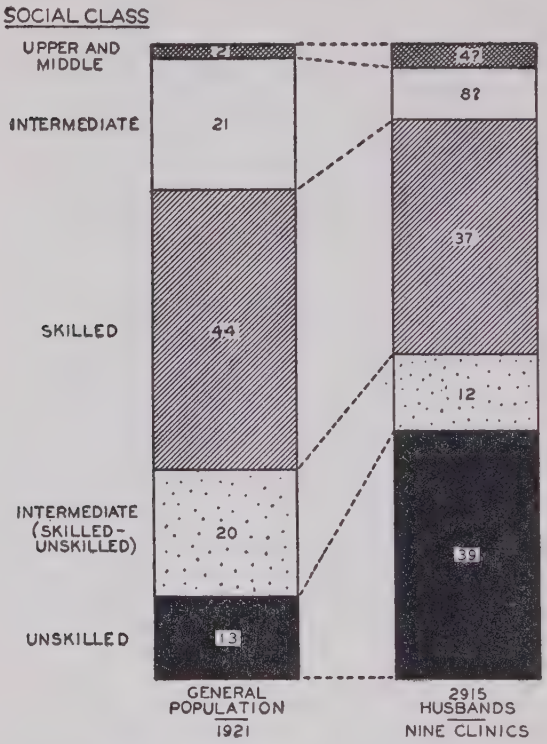

Fig. 1. Social Classes Represented in British Birth Control Clinics Compared with Percentile Distribution in Census of General Population in England and Wales

(See Table VI, Appendix A)

complete in social and economic data. This is due to the determined efforts of California physicians to keep

nearly all except poverty stricken people out of free clinics, which efforts are of course applied particularly in the public health departments. Thus the Los Angeles County Health Department reports that one-fifth of their birth control patients had no incomes and one-third had incomes of less than $100 a month. It seems that California free clinics are already as eugenic as admittance by income data can make them; that is, as eugenic as they could be made without an elaborate analysis of I.Q. and heredity.

The exact status of all their birth control clients is of course also known to the very intensive sex hygiene service of the Chicago Jewish Social Service (No. 55), and also to the Pioneer Health Center (No. 38) in London. This latter is not a birth control clinic nor devoted especially to contraception, but is a scientific experiment to see what can be done with a limited number of poor families by extending to them over a period of about five years all kinds of intensive health aids, including contraception. Among the 103 families given contraceptive advice by the Chicago Jewish Social Service were 71 cases of serious physical illness and 66 cases of mental trouble in either the husband or the wife, besides 17 cases where children were seriously defective. (L-8) These projects at Chicago and at Peckham, London, carried on by Jewish philanthropists, would seem to be among the most significant pieces of eugenic work being done in the world, but they are done with one of the races that need it least, if one is to judge from figures for Jewish infant mortality (R-6, p. 79), and by the proportion of the Jews seeking higher education. "To him that hath shall be given," and to this race that is clever and strong shall be given the priv-

ilege of profiting by eugenics to become yet more strong and clever.

Vienna. In this war-ruined city where nearly all citizens are poor, the tiny average wage of Herr Ferch's patients (five dollars weekly when employed at all) is no clear guide to the human quality of the various patients to whom he and his wife have dedicated their lives. But the Herculean effort expended in their eight clinics strongly suggests a project in aid of the most pitiable classes. One of the questions asked is this: "Have you a home, or do you merely bunk by night in a Government dormitory?" This question shows why the law making contraception illegal in Catholic Austria can no longer apply. A city many of whose people have a roof only during the night hours cannot have children born indiscriminately.

EXCESS OF UNSKILLED AND UPPER CLASS CLIENTS

As we have said, the population at each end of the social scale is disproportionately represented, while there is a deficiency of the artisan and middle classes among the patients.

Explanation. The probable explanation of the present surplus of unskilled workmen and of the great relative (though tiny actual) representation of professional and monied classes, with a corresponding deficiency of the artisan and middle classes, is that the unskilled husband has not in the past assisted in any attempts at birth control, and the wives now flock to secure it in a form not requiring male coöperation. On the other hand the highest and the middle classes have both practiced some passable form of control, but only the highest have the

initiative and leisure to visit the clinics looking for some more convenient or more esthetic method. An additional explanation may be that the artisan-middle classes are neither attracted by printed matter, as are the upper classes, nor apt to be brought in by social workers and philanthropic souls as are the very poor and unskilled, whose conspicuously sorry plight has attracted such notice.

Eugenic Significance. The preponderance of the unskilled at the clinics should tend toward a eugenic effect in directly reducing their birth-rate and also in doing the same for some of the actual degenerates scattered among them. I cannot agree with Mr. Himes (H-3), although he is endorsing the general opinion of English thinkers, when he says, "The group which one might describe as 'chronic paupers' is hardly represented among the clinic patients."—Nor are the feebleminded. One may perhaps agree that really inferior women will not be found at the clinics, but what about the *normal wives* of quite inferior men? Some will argue that no normal woman ever marries a real defective. But on the other hand, it may be urged that a group of hundreds and hundreds of unskilled men will contain some pretty poor mentalities, whatever their label.

The tremendous surplusage of unskilled husbands which I have demonstrated in Mr. Himes' figures may be a more important piece of evidence than any mere opinions about unfit strains not being reached. We cannot expect a woman when asked her husband's occupation to reply, "chronic pauper," nor yet "feebleminded." But the Charities know that there are many paupers and feeble-

minded among their clients who, at first glance, in the office, seem to be of ordinary intelligence. The fact that the number of unskilled husbands is out of all proportion admits the suspicion that many blood strains of feeble-mindedness or pauperism are to be found among the husbands if not among the wives.

Shall one then agree or not agree with Mr. Himes that in some respects the clinics' influence would seem to be dysgenic? By failing to attract the skilled artisans, they appear to function exactly as Major Darwin, president of the English Eugenic Society, recommends: "It is both legitimate and convenient, as we have seen, to look to the day laborer as being typical of the class in which the size of families is in need of being held in check, and to the skilled artisan as being typical of the class in which fairly large families are especially to be desired." (D-2, p. 452) Praise for the intelligence of the mechanics has also been voiced in the United States.[1]

It remains to ask how dangerous eugenically is the slight surplus of the more privileged classes at most of these clinics. It may be noted that Los Angeles is exceptional in having a deficiency of this class. For the other special clinics, the defense must be that the wealthier classes have already had effective methods as shown by their birth-rate for some decades past, and the clinics merely serve to change the type of method in use. Leonard Darwin is of the opinion that the birth-rate of such a small fraction of the population is not of great importance in

[1] See address by Dr. Edward E. Free before the American Society of Mechanical Engineers, on the intelligence rating of many thousands of individuals, quoted in *The Eugenical News*, January 1929, p. 8.

any case. (D-2) The figure shows the numerical insignificance of these classes, and it is certain that they are not found among the clients of the many public and social welfare centers.

UNUSUAL SOCIAL STATUS AT THE THREE PIONEER CLINICS

The first three clinics to be founded, in London (Stopes, No. 26), in New York (No. 40), and in Chicago (No. 49) appear to have treated a somewhat different range of classes from the other clinics, with a relatively larger proportion of upper class representatives. If the reader will examine Table IV, it will be seen that the Stopes and New York patients had the lowest fertility and child mortality listed. Hence, they were probably on the whole of a higher social grade than those in other clinics. In Los Angeles and Manchester, the families are about half as large again as in London and New York; in Frankfort, yet larger. The families in the Baltimore Clinic No. 65, whose figures were published too late for inclusion, would take rank above the largest in Table IV, with 6.7 pregnancies and 5.3 living children per patient.

No other special or general clinics have been heralded with as much publicity, and hence none have become so well known to the educated classes; therefore, these classes have been unduly represented in the pioneer clinics.

Most clinics are not frequented by the traveling public, but the Stopes Clinic was deliberately made accessible to globe trotters and others from a distance. The New York Clinic, through its association with the American Birth Control League and with Mrs. Sanger, is the center

of the movement for America, and in some ways, the world center. At Walworth, on the contrary, the patients live in the neighborhood and are in such humble circumstances that often the patient's family occupies only one room, Mrs. Fuller tells me. Still, she does not consider that her clinic reaches the lowest classes except occasionally. She believes the most encouraging feature is that many slum dwellers come for aid who have only two or three children as yet. Walworth is reached from the better parts of London by a long bus trip and walk.

The New York law allowing contraceptive advice only 'to cure or prevent disease" operates in two ways to reduce the proportion of poorer clients and to increase that of the upper income groups. Women presenting no physical or mental condition "indicating" contraceptive care are turned away, however poor they may be, or however heavy their economic or family burdens.[2] On the other hand, the better conditioned women, who are also better informed and possess greater initiative, if they happen to have no family physician, perforce seek care from the

[2] To date the rank and file of general practitioners have not encouraged their clients to seek birth control advice from them, still less do they initiate it. Though they are legally allowed to give the care, this is only by exception, and as the exempting law in New York is ambiguously worded many are not at all clear as to their rights in the matter. All the more because the Medical Practice Act specifically threatens the violator of any part of the section of the New York Penal Code which prohibits contraception as indecent (Sect. 1142, passed in *1873*) with loss of license, and other discipline, while it fails to mention the exempting law passed eight years later (Sect. 1145, of *1881*). Until the law is changed and physicians generally become aware of it, they naturally are not going to risk their professional reputation by holding themselves open to prosecution, even though it is reasonably certain they will be upheld in court.

only organized provision open to the general public. The few newly opened "pay clinics" for the middle income groups do not as yet furnish birth control advice.

Any new clinic may wisely seek well-to-do patients at first, in order to acquire money and sympathy for its main object, which is to help the poor. Similarly, the pioneers of the whole movement have been necessarily dependent upon the wealthier classes in an undue degree. We should not now turn and rend them for following the very course which alone has paved the way for all the subsequent work.

It should, however, be noted that these well advertised centers are the very ones at present to accomplish some birth increase among clients who come desiring more children rather than the means to avoid them. Dr. Stopes (S-24) reports that 3.3 per cent of her 5,000 cases came to her center seeking relief for sterility. A similar report comes from New York No. 40, and in the hospital clinics there is a tendency to combine sterility care with the contraceptive service.

It may be noted also from Table IV that the New York clinic averaged a more fertile class the second year than the first—hence, probably a socially lower class. A sample from the third year shows a continuation of the trend. Thus the trend of the whole movement within and without the parent clinics grows ever more eugenic.

Finally, as to Chicago, the lumped figures for two clinics show that the unskilled are reached in due, though no more than due, proportion (Appendix A). Professor Elliot (E-5), of Northwestern University, fails to be cheered by this, or by the usual deficit of the groups between the

unskilled and the upper classes, probably because he does not regard, as we do, excess upper class representation as unimportant. Though a supporter of the work of the Illinois Birth Control League, he wrote that "every clinic should have a social case-worker," for "the distribution of Chicago cases indicates that the claim that the leagues have not yet begun to reach the poor in whose interest they preach is in some degree justified."

When the Illinois League publishes its later figures, including all the small, outlying clinics established especially to help the poor, and separated from the central clinic which carries the financial and publicity burden of the whole work, a far better balanced showing will appear. One of these clinics is for colored people. Some are carried on determinedly despite the few patients and relatively high rents. As the work is better understood, the poor-district clinics will increase and money will be given for them on their merits rather than through the interest aroused by helping well-to-do women in Central Chicago. Thus the work will continue to become more eugenic.

If there are too many of the privileged class patients in English, New York, and Central Chicago clinics, this matters little eugenically, according to Leonard Darwin, as he thinks these people were already practicing family limitation.

THE SKILLED ARTISANS

About the skilled artisans we are a good bit in the dark statistically and logically. We only know that they are represented in deficient proportion in England and Chicago, and perhaps in Newark, and our readers will not

completely agree on eugenic grounds whether to grieve about it or rejoice over it with Major Darwin, who sees them as the class to be preserved.

For the moment we must not reproach the clinics, nor those responsible for the unsatisfactory type of public statistics available on occupation and wages. It is the turn of psychologists and philosophers to make the next move and tell us whether we want to increase or decrease the proportion of skilled workmen. Meanwhile clinics will be deserving well of their country wherever their unskilled clientele (or those earning $25 or less) rises to 30 per cent of the total patients.

REACHING THE POOR THE MAIN OBJECT

That too many children are a greater burden on poor parents than on the well-to-do will be admitted as obvious. It is not always recognized however that marital dissension between husband and wife, because of her fear that their relations will involve another pregnancy, is more painful just in proportion as the poor have fewer keen pleasures aside from those of sex than have the rich, and as other bonds between husband and wife are fewer. Moreover, the fear of losing financial support together with a deserting husband must increase the misery of the poor man's wife who is afraid to respond wholeheartedly to his marital advances.

Consider the lower-class wife in the United States, half-conscious that by deserting to the next state her husband can easily find some new housemate, perhaps one who knows how to avoid presenting him with a new infant every year. Such a woman is in a pitiful and precarious

position as long as she lacks the information which is possessed by women more knowing and often less scrupulous than she.

HOW INCREASE SERVICE TO THE LESS FIT?

There are two main lines of procedure by which humanitarians may strive along eugenic lines to get special access to the unfit:

(a) They may work through existing hospitals and charities as do three-fifths of the American groups. Although Table I shows that by this method the number of patients who are reached generally remains small, yet there are exceptions like Denver No. 69 and the Los Angeles public clinics. Whenever hospital clinics have special committees looking out for their interests, the numbers are kept up. Incidental services in gynecological departments fare worse in this respect and fail to reach anything like the proportion of needy cases.

(b) Or a clinic may constitute itself a propagandist center like Stopes' and the Clinical Research Bureau in New York, or Chicago No. 49. Then it will reach many unfit, but many fit as well, for which it may offer a fair excuse by claiming that these fit would have limited their families in any event.

Los Angeles No. 57 has shown most ability for fast growth by attracting chiefly the needier patients. Nevertheless, it is not necessarily a model for other clinics, since its environment appears to have been far more progressive and less hostile than is found elsewhere, and coöperation with county officials and welfare agencies has been very close.

CASE WORK THE ULTIMATE MEANS OF REACHING THE LESS FIT

Professor Elliot has demanded for every clinic a social case-worker. (E-5) But is not more needed than merely *a* case-worker? Complete correlation of the clinics with all the case-work within the entire community is what the future welfare of the race demands. Case-workers come in contact with larger numbers of the unfit than any other profession and they alone can know which families may be adjudged truly unfit and not merely temporarily out of funds, or with some passing disability like acute illness.

Only when the increase of the unfit is cut down will the middle classes secure a lightening of their share of the huge taxes supporting institutions for the unfit (defectives, dependents and delinquents)—taxes now greater than for any other object, with the possible exception of schools. (B-32) Also if the competition of morons is cut off everyone will be able to command standard wages in any employment, instead of only the low wages paid in occupations open to morons. Thus the middle classes will be able for two excellent reasons to afford more children themselves. Cutting off the increase of the unfit may prevent degeneration, but as Professor Conklin says, only the increase of the fittest can lead us in the direction of a new and better and really higher race. (C-6) It would seem that the lightening of taxes would aid the fittest to spend more money on the production of their own offspring.

Hence we long chiefly for the day when birth control will be an integral part of every Charity Organization Society. We welcome the Chicago Jewish Social Service

as the great pioneer. They do their work at great cost—$40 for a year's follow-up on each family—but it seems worth it.

In certain other philanthropic spheres, such as criminology, in hospital service to the poor, and in child welfare work, progress is closely bound up with increase of field case-work. Is this to be the outcome in birth control also? Eugenic considerations point to this, for only when the charity societies sort out the cases of the least fit members of society and then follow them up with persistent contraceptive instruction, may one see real progress. But at present welfare workers are not allowed by their directors to be known as active in contraceptive work. Some exceptions are found, however, and the workers, in their national association, were able to endorse birth control in 1928. It must be remembered that sometimes directors have to consider possible reductions of state subsidies if any group in the state is seriously offended.

Until the public and the medical profession are sufficiently enlightened and courageous to fight for and with the social service folk, birth control cannot become an integral part of the work in which its need is most apparent, that of the social case-worker.

PROPAGANDISTS AND THE BIRTH-RATE AMONG THE FIT

Those in positions of responsibility, as authors and workers in the birth control movement, have also a duty at the other end of the eugenic scale.

If control of fertility is in part restrictive, it should be no less constructive in other quarters. If we take steps

to limit the undesirables, it behooves us also to stimulate the increase of desirables. If we abet the poor in limiting their babies to the number they can fitly rear, we have an equal duty to incite the intelligent and healthy to bear all the youngsters they have the means and the moral resources to make into serviceable citizens. If, in the interests of sexual morality and peace of mind, we urge early marriage and provide with "information" the young couple who cannot yet start a nursery, it is equally incumbent on us to urge that the start be made at the earliest possible moment.

All this is frequently pointed out at birth control conferences and in birth control journals. But some people feel it is said too mildly; that somehow it does not bite in. If true, this is a pity, for birth control always secures a wide and attentive audience, among whom are many of our fittest youth.

Lest this complaint be made of the present volume the following sections have been included and made as strong as truth warrants.

"SUICIDE" AMONG THE PRIVILEGED CLASSES

"One man's meat is another man's poison." More birth control may be just the thing to feed the unskilled classes as fast as we can; but it should be labeled "Poison" when handed to the scholar class who have been committing race suicide for generations,—indeed, ever since the growth of monasteries as centers of learning. In those days a residue, however, of the learned and great always had very large families. Today it is hard to find learned or great men who have more than two or three children.

As shown in the Introduction, for three-quarters of the educated households birth control must be carefully provided. But like other powerful instruments its control and direction requires deep understanding by each pair. It is doubtful whether it is patriotic ever to purvey it to the privileged classes without accompanying warnings concerning the present birth-rate of these classes. Huntington and Whitney, whose notable volume should be read, consider that at about the end of a century 1,000 college graduates and 1,000 miners will be represented respectively by 200 and 3,700 descendants. (H-10) With more certainty they prove that among college graduates one couple in every four is childless. At one leading college it is nearer to two in four. No fact whatever requires to be scanned more searchingly by our young people. It must not be obscured by personal ambition or grief for the world's pressure of population.

AGE AND INFERTILITY

With passing years, fertility declines. (P-1) (F-2) The absolute inevitability of this has been too little realized.

The process may be compared to the ravages of time on the complexion. The skin at thirty is not "that school-girl complexion" of fourteen. And why? There are fifty reasons. You may, by care, obviate forty-nine of these ravages but one will yet befall you to tell the tale of years. Scars from accident, and from disease; degeneration in digestion, and failures in nutrition; bacterial parasites—one gets rid of them but they leave a trail of discoloration if not a scar; a changed psychology brings wrinkles; the wind, the sun, frost-bite, do their work; the very nature of the cells changes.

How equally numerous are the vicissitudes inevitable to the reproductive system, which is much more complex! And the chances for defect must be multiplied by two since it takes two individuals to insure fertility. Somewhere along the path of the two male and female processes, disaster may occur, having arisen from accidents either great or small. Or quite a minor defect may result in the gears of the two processes failing to mesh. Infertility follows.

It is well understood in the mechanical world that the older mechanism is *inevitably* defective. The motor-car five years old is mechanically as satisfactory as ever in a hundred parts, but in one or more parts it is defective—consequently it simply doesn't run until the part is replaced. This cannot be done in man. Men and women of means will not buy a five-year old car but they do marry thirty-year old partners and are then surprised if they are childless. See also Chapter VIII for observations on college women.

A single child, borne early, will develop the mother's physique and ward off the insidious changes which some physicians suspect in women who do not follow the normal animal course of early fertility. (P-1)

To put off child-bearing exposes one not only to the physical perils of age but also to the perils of divorce, for it is the childless marriages that end far oftenest in divorce. Thus temporary voluntary childlessness becomes permanent and involuntary through the intervention of divorce not followed by successful remarriage.

But above all, do not delay marriage too long lest one partner or the other sterilize himself through disease ac-

quired in illicit indulgence or through the psychic inability to marry which attacks those who delay too long.

SUMMARY

It appears that the birth control movement will become an even mightier eugenic force as fast as two things occur: Its leaders must clarify their speech to the upper classes, warning them more effectively of the perils to fertility, particularly that of increasing age. Secondly, although unskilled workmen's wives already form the great part of the clientele, a eugenic effect will be made on the race only when the public supports social workers in incorporating birth control clinics into their general welfare scheme.

CHAPTER V

PRESENT PRACTICE IN FOUNDING AND FINANCING

CAPITAL and clients are prime necessities for most commercial, educational and other human enterprises, and birth control centers are no exception to this rule. The difficulties with law and opinion are quite subsidiary except in countries where religious opposition is strongly entrenched, and in a few states like Pennsylvania and Connecticut where the law is definitely prohibitive.

Money is needed, as all can see, for rent and equipment, but also, as many fail to perceive, in order to obtain the doctors and the patients.

Because it is customary for physicians to serve at little or no salary in every sort of clinic for the poor, it is a mistake to think that birth control centers can be started on a slight financial foundation if only legal difficulties can be gotten out of the way. This mistaken view seems to confuse, if I may use an analogy, the difficulty of obtaining capital to start a standardized process with the much greater difficulty of obtaining capital for a new one. A very small capital of his own will enable an experienced factory manager of a perfectly standardized product to set up a duplicate factory of his own—for the banks will lend him the remainder. But if he is inexperienced and the product a perfectly new invention, they will lend him

next to nothing and he must have an enormous proportion of capital of his own.

The physician whom one asks to serve in a clinic is like the banker. He will invest his time and his reputation in an eye clinic or heart clinic or any standardized clinic for which he is fitted, for he knows the whole matter will work out in a standardized way; he will draw interest for years on his investment by increase of his reputation and his experience. But if one asks him to invest his time and his reputation, which are usually all he has with which to make his living, in a comparatively new and uncertain invention like a birth control clinic, he is going to refuse this investment. Why should not the interested philanthropists themselves invest? They may well prepare their minds to hire him exactly as they would hire a chemist or an engineer for a chair in a university, in which case, they endow the chair and then they are able to get a first-class chemist, say, to leave all his interesting openings in industrial chemistry and come to engage in the routine of teaching.

Birth control work not only seems a risky investment to a doctor, just as it is risky for a man to take a professorship in a college for which not a cent of endowment has as yet been raised, but it may be monotonous work, uninteresting to young physicians. A bright young physician may weary of it. However, the work of many other clinics is monotonous; prescribing eye-glasses for instance. But doctors endure it because it is an integral and necessary part of their careers. One ventures to say that in time it will be so with birth control work.

Whether it be true that doctors would be justified in de-

manding heavy guarantees for birth control we must gratefully admit that twenty-five generous physicians, in the United States alone, have been found willing to undertake the work gratuitously or on salaries precariously raised by annual subscription. One or two of these physicians have been rewarded by large increases in their private practice and a broader reputation.

If only the work were well financed, clinics might be found in most localities.

HOW CERTAIN CLINICS ARE FINANCED

The Walworth Clinic is a model of finance, as of most executive and administrative phases. The scope of what is attempted is narrower than at one or two places elsewhere but near to perfection as far as it extends. It publishes a succinct financial report. (S-14) By its economical method of examination and teaching it treated 1,973 new cases in 1926 with also 3,105 return visits, chiefly of women coming for supplies, in 390 hours plus the considerable overtime that the staff stayed after scheduled hours.

The 1927–8 budget of £1,265 was made up (a) of patients' payments and (b) of £845 donated by about 200 persons. This £845 approximately paid the medical and other salaries and the rent, etc., while patients' fees and sales of appliances financed the medical expenses other than salaries. The patients paid about £70 more than the preceding year, but the donations fell off £300, and the new cases, but not the return visits, diminished by 333. This tendency for the center to become self-supporting has been continuously evident, with as many old

patients as ever, but fewer new patients. Fewer new patients appear in 1927–8 in a number of the older English clinics.

For the entirely free Stopes clinic, Dr. Stopes herself supplied all the funds, with assistance from her husband H. V. Roe, a manufacturer and pioneer in aviation. (S-24)

The Committee on Maternal Health, which is not of course, a clinic, is financed largely by donations secured by its treasurer, Mrs. Gertrude M. Pinchot, and through one of the foundations.

Money for the Clinical Research Bureau (No. 40) has been privately solicited by Margaret Sanger and her board of managers, with some foundation help, not always announced publicly at the time.

The clinics in hospitals and so on are of course not financed separately from the institutions of which they are a part. Pasadena (No. 59) and Mandel (No. 56), though departments of hospitals, get special appropriations, the first from the Community Chest, the second a special budget of $1,200 for its half-time social worker. Los Angeles (No. 57) raised all its funds specially and privately, its doctors donating their time, but now it has received two bequests: $30,000 from Dr. Brainerd, and $150,000 from Clara Baldwin Stocker.

The Illinois Birth Control League received $6,644 in contributions and dues in 1926, and $4,165.73 from the sale of supplies and fees from patients able to pay. Its 1929 report says it is half self-supporting, as Los Angeles has been in the past.

The Detroit Clinic is financed by the Jewish Welfare

Federation of that city although only ten per cent of its patients are Jews.

The Austrian Bund für Geburtenregelung has, our agent was told, about 200 members who pay one schilling (fourteen cents) yearly. This of course goes no distance at all towards paying the expenses of their service to thousands of women, for there is no charge made for referring patients to physicians, and the physicians' fees and price of materials, which total eight to ten schillings ($1.25 to $1.50) per patient are refunded to all who come from the unemployed part of the population, which in 1928 was about twenty per cent. The deficit is made up from the receipts from Herr Ferch's illustrated lectures on the population problem. He has delivered more than a thousand of these, especially before labor unions. The advice centers cost little aside from the physicians' services and materials. They are staffed by volunteers and get quarters rent-free from the labor unions or the municipality.

COST PER CASE

Some American clinics do not publish the amount and source and expenditure of their budgets, and state that cost per case has not yet been computed.[1] But cannot this computation be approximated for unendowed clinics by performing one problem in division; namely, amount annually collected, divided by number of new patients during the period? It is then possible to say, "this year's cost per patient is less than this much," using the word "less" to indicate that some of the budget has been spent for revisits made in the current year by or to patients

[1] See Davis (D-7 Chapter XXI) on Costs, and Cost Accounting.

CHARGES FOR MATERIAL AND FEES AND APPROXIMATE COST PER PATIENT

(All centers in this list take some, many or all free patients. "At cost" for materials may mean around $2.50)

Number and Name from Table I		Fee	Charges for Materials	Approximate Annual Cost per New Case
7–13	German Bund	Free to indigent	—	—
17–24	Vienna	$1.25 to $1.50 or free	Included in fee	—
26	Stopes	None	Not furnished	—
27	Walworth	1 shilling	Half price	Less than $3.60 in 1926, $4.06 in 1927 and $4.47 in 1928 (1)
36	Aberdeen	1 shilling	—	Less than $6.03
39	Mirfield	7 shillings or free	—	—
40	New York	Sliding scale to free	Cost or free	Less than $6.69
41	New York Infirmary	25¢ to 50¢	At cost	—
42	Mt. Sinai	25¢	Free	—
45	Sloane	None	At cost	—
46	Nursery and Child's	25¢	Free	—
47	Lenox Hill	50¢	At cost	—
48	Jewish	25¢	—	—
49–54	Illinois	$7.50 to $2.00	Not free	—
55	Chicago Jewish	None	—	$40.00
56	Mandel	50¢ to free	75¢ to free	—
57	Los Angeles	None	At cost	$4.50 including supplies
59	Pasadena	None	$2.25 or free	$1.41 plus $1.50 for materials if given free
64	Detroit	None	Wholesale cost	$12.00, low, for a new clinic
65	Baltimore	$1.00 to $15.00	If patient can pay	—
66	Cleveland	Sliding scale (2)	$5.00 or less	
68	Newark	25¢ to $25.00	Cost or free	—

(1) The costs mounting from year to year reflect the increasing proportion of "return visits" not counted.

(2) The Cleveland Clinic has a sliding scale of prices according to income and size of family as follows:

Weekly Income	*Number of Children*	*Appliance*	*Medication*	*Total*
$25.00	one	$1.25	$ .15	$1.40
	two	1.00	.15	1.15
	three	.75	.15	.90
	four	.25	.15	.40
	five	.25	.10	.35
$30.00	one	$1.50	$ .50	$2.00
	two	1.25	.50	1.75
	three	1.00	.25	1.25
	four	.75	.25	1.00
	five	.50	.15	.65
$35.00	one	$4.00	$ .50	$4.50
	two	3.00	.50	3.50
	three	2.00	.50	2.50
	four	1.00	.50	1.50
	five	.75	.25	1.00
$40.00	one	$5.00	$ .50	$5.50
	two	4.00	.50	4.50
	three	3.50	.50	4.00
	four	3.00	.50	3.50
	five	2.00	.25	2.25

whose cases originated in an earlier year. Thus the annual cost per new case as given in the accompanying list is only approximate and it must be realized that the "new case costs" have concealed in them whatever was spent that year on "old cases."

At present, students of hospital out-patient services are concentrating on trying to get satisfactory statistics of *per visit* costs. These tend to average from fifty cents to a dollar, or up to a dollar and a half in a few out-patient departments, and vary from clinic to clinic according to the specialty. But high-grade service according to the Davis Handbook (D-7) can never be given for less than seventy-five cents per average visit, while gynecological treatment—a particularly expensive specialty—has been found in one carefully-accounted clinic to cost $2.09 per visit.

As clinics connected with hospitals are thought to be much more economical to run than special clinics unconnected with a hospital, one is again favorably impressed with the very low cost for their gynecological work which some of the special birth control clinics have managed. It has been supposed that when hospitals can be induced to take over all the birth control work, it will cost less than now, when much of it has to be done in special clinics. Does the list bear this out? The Hospital Dispensary No. 59 at Pasadena reports $2.91 as the cost of one visit or case (no returns asked there) when materials are furnished. According to Davis it costs the Woman's Hospital (No. 43), where an especial accounting effort has been made, $2.09 per dispensary visit to treat women's conditions, including medicine and materials. The costs

in special clinics, at least in America, appear to be greater than this.

The case cost of the Illinois League was more than twice that of the Walworth, and in another young clinic it was four times as great. I have not printed these exact amounts in the table lest they be misunderstood. The Illinois figure is not comparable to those of Walworth and of the Clinical Research Bureau (No. 40), because it includes all the associated expenses of propaganda and publicity whereas Walworth has the Malthusian League behind it and the Clinical Research Bureau until recently had the support of the American Birth Control League with a separate budget. These leagues carry some of the publicity expense for the clinics in London and New York. Illinois costs have also been raised because of rapid expansion into five real slum neighborhoods.

At Walworth the shilling fee is remitted when necessary and materials furnished at half drugstore rate in order to coax patients to return and report. (F-6) The New York Clinical Research fee is on a sliding scale with many free patients, and materials are paid for by patient when possible. Where the wage is $50 weekly and there is but one child, $5 is asked. Details for other clinics' fees may be found in the list.

RAISING MONEY FOR BIRTH CONTROL

If it is too soon for birth control clinics to compute their case costs, it is not too soon for them to publish their debit and credit columns and list of contributors as does Walworth and as all charities appealing for public funds ought to do. The birth control clinics have an inferiority

complex! They should publish less apologetic and more conventional booklets, decked out with all the paraphernalia of finance, audit, and a treasurer's address somewhere in Wall Street, thus affirming their right to march with all the other health charities and depending calmly on the first-class arguments they are able to muster as well as on the first-class scientific men who have within the last three or four years become eager to lend their names to the movement.

It would appear that one of the most logical ways of raising funds for the clinics would be to determine the budget needed, something more than $10,000 in a large city, compute what proportion this is of the Community Chest annually raised for philanthropy, and then broadcast an appeal to all who give to this eternal salvage fund. Tell them that they give, in the largest cities, $1,000,000 or more for *cure* of poverty and illness and that now one per cent of that amount is wanted to *prevent* the arrival of infants destined to be either poor or ill or both. Therefore, each giver to the Community Chest is asked to give one penny for birth control to every dollar he gives the Chest. If each will do so, the birth control budget will be raised. As all will not do this, and because it will be too expensive to abstract their single pennies from all the dollar givers to the Chest Fund, it will be necessary to ask the large givers for at least two cents on the dollar.

Some far-seeing philanthropists are refusing to take on any *new* charities until birth control is properly organized to begin fighting the present terrific multiplication of the unfit. Their slogan is "Millions for defense against degeneracy, but not one cent for tribute to it;" that is, not

one cent beyond their customary contributions to the Community Chest, Red Cross, hospitals, church charities, etc. If any *new* aids are to be devised for the dependents, delinquents and defectives, let it be after some attempt has been made to cut off the ever increasing supply of them.

The far-sighted Jews of Chicago have not scrupled to pay $40 annually per family in working with over 100 families, many of whom were very degenerate, and whom the Jewish philanthropists felt were already a sufficient burden on the life of their community without more babies being born to them.

This figure, $40, may be compared with the cost of family relief averaged for sixteen cities in the United States. A report published by the University of Chicago in 1929 states that there are fifty-five families always on the charity books for each 10,000 population and $8,800 is annually spent in the same unit for "family relief" alone. (U-7) Thus an average of $160 for annual relief per family may be compared with the $40 cost of initial year of training in birth control in a very degenerate class (which may or may not have been a stupid class) of people.

OBTAINING CLIENTS

Mrs. Evelyn Fuller says in her report: "In order to avoid disappointment and waste of time and money, great care should be taken to make a new center known as widely as possible before it is actually opened." (F-6) She recommends: (1) meetings, with advertising leaflets, for working women only, or for both sexes; (2) circularization or visitation of *all* social workers in the neighborhood;

(3) the same for doctors at all local hospitals, welfare centers, etc.; (4) articles or advertisements in the local press.

In American states having quasi-obstacles of legal nature, it is best to use chiefly the second and third methods.

The difficulty of attracting really needy clients also encourages the use of the second and third methods. It is easier to obtain wide-awake upper-class clients merely seeking a safer or more comfortable contraceptive than the one they already know, than it is to obtain the lowest class clients for whose own sake and the race's sake birth control is most imperative.

To cultivate the coöperation of "the Charities" in sending the neediest cases, a high-priced social worker will be required, or else a volunteer of the highest ability and social standing. Only a superior person will be of the necessary calibre for pioneer work. One may hire a young woman at a low salary who will promise to go out and get the coöperation of all the social agencies in sending in the unfortunates who need birth control. But at the end of the year she will too often be found not to have redeemed her promise. She has been overcome by the unpleasantness she has met with and the inertia, and the need for reminding everybody seventy times seven about the new work. A woman of greater persistence and tact should have been engaged, at a better salary. Or, if an unproved person is taken, she should be continued from month to month only if she brings in the clients satisfactorily. Difficulty of this sort is said by some to have caused the closing of the Birth Control League's Brooklyn Clinic. It is probable that their "Columbus Hill" clinic also closed for lack of patients.

A volunteer, a mature woman well known and well connected among the people and institutions of her city, can probably do much more to establish lines of liaison between the clinic and all the other philanthropies. In the same way she may succeed in raising the funds. Of course, such success will require many hours of devotion daily. Thus it has been in Chicago, where Mrs. Carpenter, the President, not only connects with the social agencies, coaxing them to send clients, but sees to it that her organization is on the "accredited" list of charities, so that appeal for funds can be made to the big business men whose ears would otherwise be closed.

At present it is the working class who compose the bulk of the clients. They are so much more numerous than any other single class in the community that, as seen in the preceding chapter, they come in goodly numbers on their own volition, unherded by the social service organizations. However, reports from fourteen sources indicate that from 5 per cent to 29 per cent of the patients even in special clinics do come through these charities. Physicians and hospitals send a quota varying from a few to at least 42 per cent. The newer American clinics differ from their predecessors strikingly. I know of three claiming to take no patients at all except as sent by the medical and welfare professions. The older clinics get most of their patients from old patients and friends, from meetings and the distribution of literature. The Illinois League's last figures, however, show these sources reduced to only 47 per cent. (C-8) Public officials in many places refer patients.

Physicians are an increasing source from which patients

come, and they and their hospitals are the whole dependence of the newer clinics aside from the social service organizations.

When the Baltimore clinic was opened, the committee of prominent doctors supporting it drafted the following letter, a model of dignity and precision, and sent it to every physician and to all hospitals and social agencies:

October 17, 1927.

To the Physicians of Maryland:

The above Committee wishes to call your attention to the following statement concerning a Bureau for Contraceptive Advice, which has been opened at 1028 North Broadway, under the direction of Dr. Bessie L. Moses.

The primary function of the Bureau will be to give advice concerning the prevention of conception to such women as may be sent to it by reputable physicians with a statement that in his or her opinion the mental or physical condition of the patient will be aggravated by further childbearing, and that he is not prepared to give the necessary advice. No advice, however, will be given to women who are already pregnant.

A secondary function will be to ascertain the efficiency of the advice given, as well as to determine the relative value of the various methods which may from time to time be recommended.

Doubtless, social service and other charitable workers will discover in the course of their duties women whom they believe to be in need of such advice. In such cases, they should advise the woman to secure a letter to the Bureau from her medical attendant; but, if that is not feasible, a statement giving the salient features of the case should be submitted, when it will be studied by one of an advisory group of doctors before the patient consults the physician in charge of the Bureau. Such a precaution is necessary to prevent advice being given in unsuitable cases, as well as to protect the physician in charge from personal solicitation.

It is the earnest desire of the Committee that the activities of the Bureau shall be conducted along the most ethical lines, and be limited entirely to those who really need its services.

White patients will be seen on Wednesdays 1:00–4:00 p.m.

Colored patients will be seen on Thursdays 1:00–4:00 p.m.

SOURCE OF GERMAN CLIENTS

In Germany the advertising methods of the marriage-advice centers are far more radical than elsewhere. They all use notices and articles in the daily press, and most of them use public bill-boards. (N-4) Some of them organize meetings, some have patients sent them by officials, by unions and by welfare workers, and some distribute handbills in labor unions or places of business. In one instance a notice is handed to every hospital patient who has undergone abortion, urging her in future to take the better means of contraception. This "direct action," praiseworthy for its efficiency, is open to the objection made to the venereal packet: it takes irregularities too much for granted. It presumes that most abortions are voluntary. Perhaps they are, but it may build up morality to refrain from saying so. However, it may be that the German wording is cautious enough to include the supposition that the woman who has miscarried has been merely imprudent in allowing pregnancy to commence when her health was not sufficient to carry it through.

SOURCE OF NEW YORK HOSPITAL CLIENTS

Let us turn away now from the special clinics anxious to get all clients who are overburdened with child-bearing, to the hospital clinics, which are as a rule anxious to avoid all clients until it is indubitably shown that there is a compelling health necessity. The hospitals have too their customary sources. In detailing these for each hospital, I will also note which person on the staff seemed to me sympathetic to the need for birth control.

At the Mount Sinai Dispensary, Dr. Max Mayer, clinic chief of gynecology, has a studious, intense interest in the technique of the problem. He takes a few patients sent him on the responsibility of known colleagues in his profession, with the health reason stated; but aside from this he is allowed to receive only those patients referred by other departments in Mt. Sinai Hospital as needing birth control because of ill health. And even then he re-examines the data. Dr. Robert T. Frank, the head of the whole gynecological service, reports that every month in heart, tuberculosis or other departments he has occasion to complain to his colleagues for sending patients for therapeutic abortion, who might have been referred for contraception, as they had been long under care at the hospital.

At Lenox Hill the social service department is strong, has thirty-one workers, and the head displays a brisk warmth towards birth control needs. The clinic takes any legal case from any source, and many social service organizations are referring clients there. On the other hand, the work of this hospital's own clinic is poorly known within this same enormous institution—so that some of their own physicians can be found telling their patients legally entitled to contraception to go two miles away across the city for it, to the Clinical Research Bureau.

The New York Infirmary for Women and Children also takes from any source, and the Henry Street Visiting Nurses send many patients there. Some too are sent by one of the other hospitals where a gynecological clinic *is* doing birth control work, but is doing it so very grudgingly that other doctors on the staff do not bother to transfer to

it their patients needing birth control, but send them elsewhere entirely. The former head of gynecology, Dr. Marie L. Chard, took the initiative at the Infirmary. The work is now under Dr. Helen W. Spencer.

At the New York Nursery & Child's all patients have a general medical examination on admission. When need of contraception is discovered it is supplied in the regular course of events. No other cases are taken. I sat for a long time and watched Dr. Nutter, who with Dr. Dennen was then in charge of the birth control work. Unconscious that he was being observed at his work, which was not at the moment contraceptive, but prenatal, he would probably have been surprised at the very favorable opinion that was being formed of his attitude towards those humble women. Many rich women would appreciate such painstaking explanations and such sincere friendliness from their physician.

At Sloane in 1927 I found an interesting division of responsibility. One physician, Dr. Jean Corwin, examined the patient to determine whether the state of her health justified birth control advice, while another physician, Dr. E. Everett Bunzel, prescribed the contraceptive. But that was not all; it appeared that the Social Service Department might relay a case in its own files, of a poverty-stricken family with eight children for instance, or an appeal from the Henry Street Visiting Nurses, not direct to Dr. Corwin, but to another specialty physician in the hospital first. *If* this physician consented, *and* Dr. Corwin consented, after the secretary to the director of the hospital made out the case sheet, then Dr. Bunzel prescribed, and *if* the woman could pay for the contracep-

tive material, she was then on the road to the protection she needed. In spite of all these pains to stay within the bounds of ethics and the law, and in spite of the interposition of five, or perhaps seven, different parties besides the patient, Sloane has managed to do more contraceptive work than any other New York hospital except two. There must be zeal somewhere to aid the miserable.

CRUCIAL RELATION OF FINANCE TO CLIENTS

In the opinion of Illinois League officials, rent is a very crucial point. If rent can be secured free, as in two Chicago centers and in most German centers and in coöperating hospital clinics, a great burden is lifted. Whereas, the raising of such a sum as $45 a month for a room used only a very few hours is a struggle. Walworth and Baltimore own their own homes. The latter by clever financing appears to have gotten its quarters free after an initial investment of less than $3,000.

Another crucial point in obtaining the needier class of clients is: can the clinic be located in a poor quarter where these women abound, or must it for financial reasons be located centrally where rich women like to come and hence are available to help pay expenses by their fees?

Or shall one's plan of work combine the advantages of economy with the eugenic advantages of reaching only the poor? One can achieve economical and eugenic results by doing one's work through the existing charities and hospitals, as in California (with two exceptions) and the New York and Chicago hospitals. But then the disadvantage is that the work fails to reach all the needy

that it should. The private center in New York accumulated 10,000 patients while the hospital clinics beginning not much later have accumulated a very few hundred.

It may be that the best scheme in the future will be a private center located in a welfare house, rent-free if possible, and with other expenses kept at a minimum, so that the great balance of its money and effort can be put on getting the associated charities to send in patients.

CHAPTER VI

PLANNING CLINICS FOR PRESENT AND FUTURE NEEDS[1]

THE need for special birth control clinics is frequently questioned. Is not any doctor who has a patient with a disorder in which childbearing is a risk to life or health expected as a matter of course to advise against conception? Is he not guilty of neglect if he omits to give such advice? Does he not know how? Is not every dispensary equipped with this knowledge? Or does this treatment call for special skill?

The actual answer by one familiar with this field is that almost any physician *can* apply present knowledge. A brief text with diagrams could show anyone with some facility in treating diseases of women what can be done. A dozen selected patients compassing the ordinary range of the need or comprising the commonest conjugal complications or local findings would suffice to demonstrate and teach present methods to physicians without such facility. The problem is much less one of special skill than one of willingness to learn. As far as the doctor and the hospital trustees are concerned there are analagous former situations not unfamiliar. The kindergarten now adopted by the teacher and the board of education as an integral part of the school system needed years of demonstration.

[1] By Robert L. Dickinson, M.D., and Louise Stevens Bryant, Ph.D., of the National Committee on Maternal Health, Inc.

The playground that is now convincing had to fight its way.

The practical answer as to the need of clinics for training and tryout may be given in terms of general experience and then as the story of one locality. We have learned that any new service idea in medicine has to go through a somewhat stereotyped course. Clinics for tuberculosis, venereal disease, heart disease, prenatal care and mental hygiene, for example, might have been expected to have been absorbed by departments already functioning and taken in at a great saving of effort and expense. But in these and like beginnings there has been need for organizations specially set up, with special workers, facing a very special budget, to prove the case by results obtained.

In such instances there have usually been a few leading medical men and women ready to sponsor and to guide the new development and even to go back to the wheelhorse work of their earlier years to see the patients and select the methods best fitted for progressive and advanced and novel treatment. With birth control, however, the stigma or slur or actual hindrance that stood in the path of those who proposed seriously to study sex situations and sex needs and to find out what were sex normalities, have been unlike those in any other medical inquiry. Until recently the senior specialists in gynecology whose interest should most be involved have held off. Attending physicians of birth control clinics have sometimes been dropped or debarred from other dispensary positions or prevented from joining medical societies, and even in the hospitals and universities where birth control advice is given there is obstruction that makes

progress slow. New York furnishes an example. Five years of birth control advice fostered in conspicuous hospitals has brought this service up to less than 450 new patients a year whereas the single Sanger clinic is running 450 new patients a month.

Of course such strictures on reluctant action by hospital departments do not apply to all institutions or imply that no progress has been made in the way of increasing service to meet the legitimate need. In some places conspicuous progress is evident, and in leading institutions. Six years of experiment is not to be expected to show a revolution in a matter that has been under wide discussion less than thirty years and which has had to meet an active and organized opposition.

GENERAL ADMINISTRATION

Granted the present need for special clinics, the next question is whether the clinic is to be a separate station, like the Baltimore Bureau, or the Clinical Research Bureau in New York and those run by the Illinois Birth Control League in Chicago, or whether it is to be in an outpatient department of a hospital. The requirements of equipment, staff and procedure will vary accordingly.

In many respects the hospital clinic is simpler. As a rule birth control advice is given in a gynecological or obstetrical service, as part of the regular treatment, the only difference being that in some places special hours or sessions are set aside and the patients instructed to attend then, and as a rule one or two physicians are assigned exclusively.

Theoretically there is no need for this separate handling

of what should be a routine provision, ready for all in need, but in the first days of a service of this kind, involving an unfamiliar idea, it is perhaps better to feature the work. The disadvantage is that a special provision of this sort is likely to be regarded by the rest of the hospital as a thing apart, and without extra care the supply of patients is not steady and all needing it are not reached.

The first thing needed in a hospital contraceptive review is to have the general medical staff fully informed and to insure their coöperation, both in referring patients and in following up those referred from the special service. This can be brought about by having a special meeting or series of staff meetings at the outset, and by thoroughly circularizing the staff. Then from time to time the clinic chief should check up references from various departments and call attention to particular cases that have been missed.

For example in one large gynecological department the chief has made a point of protesting to the medical, tuberculosis or cardiac-renal departments when cases under their regular care are referred to him for therapeutic abortion, which might have been saved from operation by an early reference for contraceptive care. A convenient time to make this impression is at the monthly staff meeting.

Some hospitals with contraceptive services admit patients only on reference from other departments in the same institution and if a patient is referred from the outside she must be first examined, and taken on as a patient in some definite clinic, such as general medicine, tuberculosis, cardiac, or gynecological. Other hospital clinics admit direct to the special service, on medical reference.

But all hospitals have a more formal system of admissions than is necessary in the special stations, perhaps demanding several visits, and this fact has a great deal to do with the small number of cases that attend the hospital clinics as compared with the others.

The cost of carrying incidental contraceptive service is practically only that of the materials, which are expensive and require renewal. Rooms, tables, instruments are those of the regular gynecological clinic and all that is needed is time assigned.

Unless some group of individuals within the hospital sponsors this service from the outset and continuously it is likely to lapse. Patients will not attend clinics where each visit takes a half a day, and very prolonged waits are the rule where they must wait their turn. Appointments are necessary, and strict attention to having the doctor there ready to receive the patients. At least one clinic executive will be needed to keep the clinic going. She should be a trained medical social worker, whether or not she is a nurse as well.

The simple and normal way in which contraceptive advice and treatment drops automatically into place in the office work of the specialist on obstetrics or disorders of women is the best argument for ultimate placing of this service in regular out-patient departments.

The Unattached Clinic. But even in localities where "Medical indications" are necessary to admission, many women unless actually what *they* call sick will not be willing to attend hospitals which they associate with serious illness and incapacity—especially as this particular health service cannot be advertised as can tuberculo-

sis, child guidance, diphtheria toxin-antitoxin, or even venereal disease. Thus for some time to come special places will be needed where women can, with a minimum of red tape, secure the necessary examination and care.

The difficulties of the unattached clinic are, first, that the initial cost is very great, because whereas in the hospital *all* the overhead is provided, as well as medical and nursing service, and in some cases even social service and clerical assistance, here the whole outfit must be set up new.

Then the unattached clinic suffers from inability to refer readily clients found to need other medical care. Even if a clinic is affiliated with a regular medical institution, if it is separated by any distance, a second visit is required, usually involving delay, and an undue proportion of failures in follow-up. Return reports on referred cases even when the patient does reach the new place, are difficult to get. The same applies to laboratory service.

Finally it is as yet to be seen what proportion of success will be obtained in the one type of clinic as against the other. Failures in special unattached clinics have ranged from thirty down to four per cent, with a tendency to remain around five. Doubtless, the discovery, in a particular place, that failures were running nearly as high as one in three among a considerable number of cases, sufficed to induce a determined overhauling of the teaching, and perhaps the medical methods used. On the other hand, it is not probable that the hospital clinics (for which we have as yet few figures) will be able to register the very low rate of four per cent failure, including

non-successes due to inadequate training of the patient. This was the figure reached by the Sanger clinic in 1925 as shown by follow-up in 1927 on some 800 patients who had used the methods for a period of more than six months. Part of this considerable measure of success was due to favoring conditions found within a special clinic, especially the concentration of effort and interest in a single type of problem. Progress in hospital services, though not impossible, is slow due to the scattering of cases among thousands of others, in scores of institutions.

OFFICE PLANS

Birth control service requires quarters and outfit very like those of out-patient departments or dispensaries which treat diseases of women or obstetric patients, but in addition to these facilities, new clinics whether attached or unattached may well make provision for particular privacies.

In this special work confidential communications are in question, intimate beyond those in any other field. These do not differ in kind from life stories necessarily revealed in the office or out-patient work of specialists in gynecology and midwifery, but they do differ somewhat in degree of detail. There are questions and answers essential to sound advice on postponement or prevention of pregnancy which common decency requires to be shielded from overhearing by other patients or nurses and doctors. For example, previous methods of control or attempted control, and success or failure with such methods, must be matters of inquiry. Abortions are to be recorded, whether spontaneous, self-induced or operative,

and the reasons therefor. The degree of considerateness of the husband must be known in order to decide the choice of method; so must the conveniences in the home for taking a douche.

All this makes desirable a desk out of earshot of others or calls for reasonably sound proof walls and not the mere curtains or screens or low partitions found in many clinics, even those of recent construction for special care of women. It is to be remembered that each woman, after instruction, needs to teach herself the mechanism of protection and can claim the consideration of a closed door. These are primary decencies. They are built into the very floor plans of the gynecological out-patient services of the Brooklyn Hospital, the new Woman's Hospital and Vanderbilt Clinic in New York and Northwestern in Chicago, and in most part at Jefferson in Philadelphia and the Michael Reese of Chicago.

We shall consider a minimum requirement and then a fully adequate or well planned equipment, as outlined in the accompanying Set-up. Such a minimum would comprise a hallway or anteroom for waiting patients, and a single small room provided with a little table for taking histories and a kitchen table for examination, with chairs, lights, wash basin, sterilizer and supplies. Also a screen or curtain and hooks and mirror for a miniature dressing room. This minimum waives much privacy for the sake of utmost economy. It is wasteful in that the doctor must take the social history as well as the medical history and must sterilize his own materials, and the work moves slowly.

As the clinic hours at first will be few—say one hour to

Set-Up for Birth Control Clinic

	Minimum	Medium	Maximum
Quarters	1. Waiting space hallway or general waiting room 2. History room and examining room in one 3. Chair behind curtain for dressing 4. Access to toilet	1. Waiting room 2. History room 3. Screen or curtain for dressing 4. Examining room 5. Toilet	1. Waiting room (with Crèche?) access to toilet 2. Two history rooms 3. Four dressing booths close to two examining rooms 4. Two examining rooms 5. Toilet 6. All walls sound proof
Equipment	Wash basin Examining table Instrument table Sterilizer Floor lamp Gloves Fitting rings Medicaments, etc. Specula	Same as Minimum	Wash basin Examining table Instr. cabinet or table Sterilizer Headlight Gloves Rings Jellies Specula Printed slip of instructions Teaching charts and models
Personnel	One doctor who takes all history and sterilizes gloves and instruments	Social worker or nurse part time or whole time Doctor part or full time	Director (Clinic Executive) Social workers to do complete follow-up Nurse or nurses Doctors Consultants

two hours together once or twice a week, it will be wise for the group sponsoring a separate station, to search for some organization making health examinations, such as a prenatal or postnatal or tuberculosis clinic or health center, which can be persuaded to rent space during hours when such space is not utilized. Thus the Los Angeles County Health Department allots certain hours to birth control service in rooms in its health centers. A doctors' office building or a doctor's office usually has free time. But with birth control still looked at askance it takes more courage than dispensaries or individual doctors usually have to lend their rooms for this use. Thus rental and equipment call at present for duplications and expenditures that ought not to be necessary.

The general *location* should be accessible to the poor and the rooms so situated in the building as to be reached directly from the street as babies or children may have to be brought along, who are not welcomed in elevators or stairs. The clinic ought not to be among a lot of business offices as in a general non-medical building because women are naturally shy of asking to be directed to a birth control clinic. The large New York clinic is in a former dwelling, of which the basement had been converted into a store. The Walworth clinic in London is in much the same type of building, where expansion to upper floors can occur as needed. The Walworth and the Stopes clinics are cheerful and tastefully decorated and there seems to be a minimum of formality in all these places. At the New York clinic, even though space is limited, a place for babies and little children is reserved where they can sleep or play while their mothers are cared for.

The *full equipment* calls for quarters essentially the same as for any well planned gynecological or obstetric outpatient service, whereby it may be seen that this work can best be done at off hours of these services or in direct connection with them. Many small rooms are the desideratum in order to avoid delay. The ideal arrangement for rooms is in the natural order of progress of the patient, not requiring her to pass through one to get at any other. The toilets must be close to examining rooms but also accessible from waiting room. One history room or cubicle goes with three examining rooms, and two dressing booths are needed for each examining room. The dressing rooms or cubicles can have low partitions, but a high wall and door shuts each from the examining room. Two examining rooms per doctor in attendance avoid idle time. A nurse covers four examining rooms and serves two doctors.

A social worker who takes the social history and does follow-up can cover two to four patients per hour depending on how much of the history has to be taken. Patients referred from other agencies take least time as they will come with preliminary reports and as their follow-up also can be cared for by the agency. The patient not so referred will take from twenty minutes to a half hour of the social worker's time at the first visit.

The *size* of the examining room depends on whether any teaching is to be done. With only patient and doctor, or patient, doctor and nurse in the room, a six-foot width suffices as one passes by the table only on one side. For teaching the unit is an eight-foot width. In either case a depth of ten feet is required.

Artificial light is even better than daylight for gynecology (as for throat examination) so windows are not essential provided other means of ventilation are ample, such as a skylight or shaft. A standing lamp may be used to throw light over the doctor's shoulder, but better still is the head band with *forehead light* connected with an overhead wire so that the lens throws a narrow beam of concentrated light.

The *doors* are to be hung so as to shield the occupants of the room from observation rather than for facility of access or exit as in ordinary architectural practice. A canvas flap over the hinge-crack further protects those within.

Floor space taken up by the swing of doors can be saved by relatively narrow door openings—even down to twenty-one inches. Sliding doors are possible, but they are rarely sound proof and are only suited to dressing cubicles on the side opening into the hallway.

The foot end of the *examining table* faces away from the door, and toward the *wash stand* and *instrument table.* The instruments are to be shielded entirely from the patient's view. The *sterilizer* should have a hood to carry off steam and heated air. Duplicate or triplicate outfits of instruments allow one set to be boiling while others are cooling or in use. Paper napkins substitute for most towels, particularly the fresh ones for each patient on pillow and table end.

ATTRACTING DOCTORS TO BIRTH CONTROL CLINIC WORK

From birth control clinics, whether located in outpatient departments of universities and hospitals or run

by lay organizations, comes the report that the work is monotonous if confined solely to the usual one or two methods of contraception. A young gynecologist in a hospital clinic may be held by enthusiasm for the cause for a series of months, but it cannot be many. In the lay birth control organizations the ordinary fee of five dollars per session of two or three hours will not hold a better type than a beginner and then not very long. The matter of payment for doctors is taken up later.

Eventually when we secure a variety of methods, and particularly when we can employ long-term methods, there will be more to interest doctors than at present. After the demonstration phase is passed and the worth of the service has been fully accepted, this advice and treatment will constitute a regular part of out-patient work in the gynecological and obstetric and urological services, and be taken as a matter of course. Meanwhile, to furnish interest that will enlist physicians of parts, keen to study methods and improve present usage and make new discoveries, we may have to add certain other services to this present work which will be presently discussed.

MEN OR WOMEN DOCTORS IN CHARGE

The non-hospital clinics have been, up to this time, almost altogether in the hands of women physicians. The hospital clinical work, on the other hand, has been commonly done by men but this is rather accidental, and in starting new clinics whether in or out of hospitals it is likely that women will lead because medical women are usually better informed on the patients' home life, and therefore more impressed with their need. They tend to

be more socially minded, and in this matter have shown more courage than their male confrères. That there are more women available at the scant salary heretofore offered may be due to the discrimination against them on the part of male chiefs of gynecological services. And it is to be remarked that this occurs in a part of medical practice which, like obstetrics and the care of children, is likely to be largely in their hands in the future. That they have not gone farther in these specialities, as my own study of the matter in many countries leads me to believe, is due to restrictions on opportunity. London, New York, Philadelphia can bear witness to distinguished skill in certain women surgeons, and anyone will be likely to agree that unnecessary surgery would decrease with increase in tenderheartedness. A service in which both men and women are active is the ideal of the future.

This consideration has a bearing on the practical issues with which this book is concerned, since special birth control clinics and even hospital clinics may be found to be better run by married medical women. (Unmarried men or women are not as well qualified to appreciate the problems.)

It is also significant that as far as our present evidence goes, where both men and women doctors have been available in birth control clinics, the patients themselves express a preference for women doctors. In ordinary clinics for women we have not often given patients the opportunity to choose, so that we do not really know what their preferences are. The health examination feature and the marriage counsel future of these clinics all seem to me to point to women—women preferably happily married and

normally sex endowed—as the attendings to be selected, when available.

PAYMENT FOR THE DOCTOR

In time dispensary physicians will receive *salaries*. Such a custom might well begin with work of this sort, at least under present conditions where there do not exist rewards in the way of experience in varied diagnosis and treatment or hopes of promotion to larger opportunities.

There is scant experience available on the matter of payment for clinic physicians, as the practice of volunteer service for all but administrative and teaching positions still dominates. Examples of places where regular clinicians are paid are the Cornell Pay Clinic in New York and some unusual services provided on a pay basis by regular out-patient departments, as for health examinations or treatment of hay fever and asthma or goitre. In all these the doctor is paid an amount which will recompense him for his time, but not, in itself, act as an inducement for men of low grade to seek the position for purely monetary reasons. Then, everything is done to conserve the doctor's time, and allow him to see as many patients as he can, to their advantage and his. This means that a maximum amount of detail is delegated to *non-medical* staff workers, whether nurses, social workers, clinic executives, or students.

Where the doctor is *not* paid, and the non-medical staff *is*, a false economy keeps the numbers of the latter down, and overloads the doctor with responsibilities not necessarily his. But where both are paid, and the doctor's cost is measurable in dollars, paid by the clinic, his time

is always the most expensive item, and savings are proportionate when it is conserved.

Promptness and enthusiasm for clinical details are both encouraged by payment of doctors. But payment by itself will not effect great changes in the absence of supervision, teaching, and professional opportunities for advancement through experience. On the other hand payment does not lower the doctor's dignity. At Cornell all on the staff, from the senior department professor to the youngest clinician, punch a time clock.

The question of referring patients from a birth control clinic to the attending doctor's private office at the patients' request is likely to turn up rather oftener than in most clinics. This is because it is not yet simple for the woman who can afford to pay to find doctors known to be willing to give advice for adequate reason. It should therefore be a matter of definition as to what is sanctioned in any given clinic. There is supposed to be a frowning on or even forbidding of this practice of reference to one's own office on the part of many high grade out-patient departments, but as a matter of fact, within reason and decency, there is little abuse of the privilege. In one birth control clinic the questioning patient is given a list of physicians known to be qualified for giving this advice and treatment.

FORMER SKILL NEWLY IN DEMAND

There is a situation in the specialty of gynecology that has so interesting a bearing on present methods of contraceptive treatment that it warrants frank speech from one who has spanned the two stages. This is the relative

neglect, for thirty years, of the dexterity and detail of attention in the office care of disorders of women brought about by undue emphasis upon surgery and the brilliant, immediate (and remunerative) results which the hospital can usually show. Where there is a fault in chosing between methods, it does not lie always with the doctor, or even chiefly with the doctor. The patient often prefers risk and suffering to get it over with. The consequence is, the old considerate art of the days of Sims, Emmet Skene, Peaslee, Smith, and Hodge (perfected when operation was really dangerous, and their lesser measures and manual skill had to be fully developed) has fallen into disuse. This stage needs revival to perfect contraceptive practice. One of the old skills was study of the life condition of the patient and then adjustment; the other was facile and finished office care. Many of our mature gynecologists as well as the younger ones need this old art for this new need.

For this type of work, office gynecology, the nurse does not need to be a registered nurse. The actual range of duties is so limited and the training in preparing the patient and sterilizing instruments so simple that reasonable intelligence and unreasoning conscience are requisites enough.

CLINICAL HISTORY FORMS

The accompanying clinical history form is one developed by the Committee on Maternal Health over a period of six years and is in use in hospital or other out-patient services in New York, Chicago, Philadelphia, Cincinnati and Atlanta. (Fig. 3.) It is also used as a model in nearly all the clinics in the country, though in some it is condensed. The form is designed to cover *all* the usual items considered desirable

CONTRACEPTIVE CLINIC RECORD

Name Surname Wife Husband

Address

Name of Hospital or Clinic

Case No.

Color: White Negro

First Visit

Check-up

Last Visit

Tot. Vis.

Closed

1 Referred by

2 Reason

Wife: **3** Age **4** Nat: U.S. Other Fa's: U.S. **5** Lang: Eng. Oth. **6** Rel: P.J.C. Oth. **7** Left Age Sch: Gr. **8** Lit. Illit. **9** Occup. (Bef. Mar.) (Pres.)

Husb- and: **10** Age **11** Nat: U.S. Other Fa's: U.S. **12** Lang: Eng. Oth. **13** Rel: P.J.C. Oth. **14** Gen. Health & Char. **15** Occup. & Industry (Reg.) (Irreg.)

16 Usual Wage day wk. mo. **17** Rent wk. mo. **18** No. Rms. **19** No. hsld. **20** Toil. Priv; not **21** Bath priv; not **22** Comment on Social Status

23 Family History (positive items, which side)

24 Wife's History (a) illnesses, (b) operations: age and present bearing:

25 Obstetrical History: (List pregnancies in order, giving for each mother's age when pregnancy ended, exact result and date; (a) Abortion. whether spontaneous, therapeutic, induced, how, month of gestation; (b) Still birth or (c) live birth, whether at term or premature, and character of labor, normal, instrumental, etc.; (d) Neo-natal death (to 2 weeks); (e) Infant death or (f) Later death, giving age and cause; (g) Age and present condition of living child.

(1)	**(6)**	**(11)**
(2)	**(7)**	**(12)**
(3)	**(8)**	**(13)**
(4)	**(9)**	**(14)**
(5)	**(10)**	**(15)**

Obstetrical Summary: **26** Age at Mar. **27** Yrs. Md. **28** Tot. Pregs. **29** Abor. **30** St. B. **31** Live B. **32** Neo-nat. D. **33** Inf. D. **34** Lat. D. **35** Liv. Chn.

Menstrual History: **36** Age Beg. **37** Int. **38** Dur. **39** Reg. Irreg. **40** Dys. **41** Menor. **42** Amen. **43** Leuc. **44** Date last period **45** Intercourse since per.?

Coitus: **46** Frequency **47** Attitude of Wife **48** Orgasm: Always Usually Occas. Never

49 Attitude of Husband **50** Prem. ejac.

51 Contraceptive practice (methods used, how long, success, failure, reason)

52 General Physical Examination: Positive findings and refers (made) (not made) (reported by)

53 Pelvic Examination: Positive findings and refers (made) (not made) (reported by)

54 Laboratory Reports: Asked for: Urine Smear Wass. Haem.
Received: ____ ____ ____ ____

55 Disease or finding for which advice given or **56** Refused because:

57 Method recommended (give exact details, size, unusual directions, etc.)

58 Payment: Amount

CMH CCR. 2000-3-30.

Signed_____M.D.

FIG. 2a. CASE RECORD FORM DEVISED BY COMMITTEE ON MATERNAL HEALTH

For file copy use tough, thick paper (not cardboard), of standard letter size, 8½ x 11, with distinctive color. Cheaper thin paper for preliminary notes. Follow-up notes on reverse of record.

FOLLOW-UP

NOTE: At least three re-visits should be made: (1) check-up on method, a week later; (2) six months after first visit; (3) a year after first visit. At each visit note whether method is being followed satisfactorily; any complaints physical or mental from wife or husband; any changes requiring re-fitting.

In case of failure try to determine exact cause. In grave cases consider advisability of interrupting pregnancy. Consider also advisability of sterilization if condition remains permanently bad and pregnancy contraindicated entirely.

Date	*Notes*	*Signature*

FIG. 2b. FOLLOW-UP NOTES FOR CASE RECORDS

Reverse of Fig. 2a, not on preliminary sheet. If additional sheets are needed use plain paper adding case number to each.

to gather from the point of view both of treatment of the patient, and of the statistical study of data and results.

Certain general points about record taking are important enough to list here. Once the form is decided upon no item should remain altogether unchecked, as this leaves doubt as to whether the question was covered. When *not noted* put a *dash*. When *not examined* put *n. e.* When examination or inquiry is made *without* any *positive finding* indicate *negative* by "*neg.*"

Some clinics find it useful to have rough draft forms on thin paper, to be filled in by each person concerned in the various stages of examination, and to have the final record typed after a review of all entries by some one responsible person, who is usually the clinic executive or head social worker. The physician making the medical examination and entries should sign each finished record. The meaning of each item and notes on the method of entry found practicable are as follows:

I. Administrative. The top section contains administrative details such as are generally found useful in identification and filing and case accounting.

Under *Name*, give surname first, wife's given name second, and husband's third. *Case Number*, at the right top should refer to the birth control series in this clinic. Where central numbers are used, as in hospital services with a unified record system, new numbers should be added for this clinic, so that some sort of numerical or chronological check is possible.

"*Referred by*" should indicate first the *outside* source, and in the case of hospital clinics, where all patients are referred over a central admission desk, the clinic or department through which the patient comes to the special service. Thus, the Associated Charities may refer a patient who will come via the general medical clinic.

"*Visit summary.*" This will be found useful in measuring the work done and the effectiveness of follow-up. It should be made on a one-year basis if this form is followed.

II. Social History. The interest of the items in this section is in part for their bearing on case treatment and success, and also as a measure of the groups in the community being served by the clinic, and its possible bearing on the differential birth-rate.

In cases referred by social agencies, it should not be necessary for the individual clinic workers to secure the social items. The coöperating agencies should have copies of the record form and should send these items when they refer the patient. In clinics where thin rough drafts are made, the outside agency which refers the needy case can use the

thin sheet. In one clinic it is planned to have special "flimsies" made which will be blank after the obstetrical history, allowing plenty of space for enumerating pregnancies and results.

But, in order to check up on the record and as an easy line to follow in the first interview, the entries should be reviewed by a clinic social worker, who can briefly question the patient and secure amplifying details.

Age should be entered to *nearest* birthday, using six months as the dividing line. Thus a person born in June 1900, would, any time up to December 1929, be called 29 years old, and after December first, 30 years old.

Nativity. Enter the *birthplace* of wife or husband on line 1, circling the "U. S." if she is a native, and abbreviating the name of the country otherwise, as "Eng.," "It.," "Irel.," etc.

The question of *stock* is most easily answered by the father's nativity, and at a glance one can see if patient is foreign born, or native of foreign born parents, or native of native parents. It does not seem useful to attempt to record any finer distinctions or to include the mother's nativity. In the case of the foreign born, the folk usages of the family will as a rule be found to follow those of the father. *Color* will be important in some clinics.

Language is an item for practical use in the individual case handling. Circle "Eng.," if this is spoken readily, or enter the other language if English is *not* spoken easily, and note if interpreter is required.

Religious affiilation. Circle "P" for Protestant, "J" for Jewish, and "C" for Catholic, and enter others as "Christ. Sc. "or "Mohammedan," or "none."

Present Occupation of wife means outside the home, for pay.

Occupation before Marriage means occupation for pay. If none, put dash.

Age and Grade Left School is the best single index to education and mentality. It will work for nearly all native women of an age apt to attend birth control clinics in the United States. For foreigners it will usually be possible to get some idea of schooling, as "finished primary," "none," "grammar," etc., and age leaving school.

Literacy. Circle *lit.* or *illit.* according to ability of woman to answer inquiries by mail.

Husband's Occupation should be given as exactly as possible to indicate his work in whatever industry he is in, as for example, "weaver in textile," "fireman in factory," "clerk in insurance office," etc. The wife may not know exactly what her husband's occupation is, and it may be necessary to question her more than perfunctorily.

Husband's Wages. Enter rate when employed, give amount to nearest dollar as stated by client, and note whether daily, weekly, monthly, or annual. This will allow persons using records for comparative purposes to make their own classification and grouping. Note irregular or seasonal employment. Total family income is not significant for this type of problem, however important in some family welfare cases. Mention if wife contributes, or other member of family.

General Health. Find by questioning whether this is good, fair or poor. Add any specific condition or habit that may be reported.

No. of Rooms. This item and that on *toilet* accommodations are significant only as placing the family socially, except that the reply as to toilet may serve to indicate the particular form of contraceptive needed.

No. in Household includes family and boarders or relatives actually living in same house.

III. Medical History. The rest of this record should be filled in by a physician.

The *Family,* and *Personal* history may, however, be secured by the referring agency in a general way, but the clinic doctor should check it over.

Obstetrical. This is perhaps the single most important group of items collected by a birth control clinic, as they are not often secured elsewhere. The list of pregnancies and results should be made first and the summary of total pregnancies, abortions, stillbirths and live births later, on the basis of this list. An exact chronological order should be observed in this list, so that sequence of results can be observed. Most histories do not make this possible, but this is a crucial point if we are to learn the facts with respect to prenatal and neonatal mortality and *numbers* of pregnancies. For example if the sequence is not indicated it is impossible to tell whether abortions occur more frequently in later pregnancies or in the earlier orders, or how infant mortality is related to order of birth.

Menstrual. This has general significance, and items about date of period and any intercourse since last period are significant in case of possible pregnancy at the time of application.

Coitus. Frequency is important because some contraceptives that are suitable for use once a week may be injurious for use daily or oftener.

The items about the wife's attitude and experience are valuable for research purposes in the study of average sex life. These data again are difficult to get in general clinics or in private practice. It is found that frank statements are general in birth control clinics.

Contraceptives used. The practice already followed by the couple should be ascertained as a means of studying the case, and for teaching the individual. The data will be found difficult to tabulate or to draw conclusions from, as the time elements are so various and the whole is perforce a matter of memory and judgment quite impossible to check.

Physical Examination. It is desirable to have a report on the results of a general examination made previously in a medical clinic and to summarize positive findings here. But where, as is usual, only the one examination is made, care should be taken to cover at least chest, heart and abdomen.

A pelvic examination should be made always and findings should be given quite exactly.

Laboratory Reports. Enter here any previous reports that have come in, and if new ones are asked for, indicate exact reference and return report when received.

Disease or *Finding* for which advice is given or refused. This is important in *any* birth control clinic, and essential in some states where this advice cannot be given for economic or social reasons. An outline for a minimum diagnosis should be worked out and followed consistently in each case.

Method Prescribed. These recommendations should be entered exactly with especial attention to notes on instruction of patient or husband.

MEDICAL INDICATIONS FOR CONTRACEPTIVE CARE

Sources. The Committee on Maternal Health has a standing sub-committee to consider this subject, as well as the allied topics of indications for therapeutic abortion and sterilization. A careful search of the literature (some fifteen hundred references have been assembled) shows almost no consideration of *prevention*, although there is a large literature of opinion and controversy with regard to interruption. There is little presentation of case material of any sort.

The New York law requires that contraceptive advice be given only "to cure or prevent disease." Consequently

every case record in the clinics includes a note on medical findings and the reason for giving or withholding care. As this precedent is followed in out-patient services in other American cities, even in states without this particular legal restriction, we are gradually accumulating a considerable mass of case material which is more relevant for our purposes than that provided in other countries, where even medical interest centers chiefly in economic and social reasons for birth control.

From a study of the meagre literature and discussion of opinion on present practice, and analysis of the case histories so far available, we are able to make the following statement:

Clinic Practice. Medical indications for contraception at present fall into two general classes so far as the wife is concerned: (*a*) *Pathological* conditions, either of active disease or functional disturbances and weaknesses, which might render pregnancy and delivery extra-hazardous, and (*b*) *Non pathological* considerations having to do with optimum conditions for pregnancy and delivery, such as the spacing of offspring. In addition there are occasional records of contraceptive advice being given primarily for the sake of the health of the prospective children, and the good of society, rather than for that of the mother. (L-8)

Among specific conditions listed, five groups bulk large:

(1) *Gynecological and Obstetrical* conditions, including recent delivery or abortion, deformed pelves, recent plastic operations, infections, and tumors; repeated dangerous pregnancies or deliveries with such symptoms as toxemia,

pernicious vomiting, convulsions; too frequent, prolonged, or severe instrumental labors, and Caesarian sections.

(2) *Cardiac* disorders, especially with decompensation.

(3) *Tuberculosis*, laryngeal, pulmonary, or osseous, if active, and sometimes if arrested.

(4) *Nephritis and hypertension*, especially where there is a history of toxemia with pregnancies.

(5) *Mental and nervous disorders*, especially insanity, feeble-mindedness, and epilepsy.

Besides these five great groups occasional entries appear of anemia, toxic goitre, extreme malnutrition, extreme obesity, diabetes, arthritis, syphilis, and gonorrhea.

Conditions of a clearly incurable kind, especially those inevitably calling for interruption of pregnancy if it occurs, should be indications for *sterilization* rather than for temporary measures. Some hospitals are developing a policy of sterilization whenever interruption is resorted to for non-accidental or incurable conditions.

Eugenic considerations include a history of insanity or feeble-mindedness or epilepsy in the immediate family, especially where defective children have already been born. Here again sterilization (without unsexing) of the mother or father is indicated, rather than temporary care.

Tuberculosis in the immediate family and active syphilis or gonorrhea of the father are other eugenic considerations not however calling sterilization into question.

Neither contraception nor sterilization has been systematically considered in the case of other large groups in the community who for their own sake or that of their possible offspring might be asked not to reproduce, such as carriers of strains of mental disability, or of haemo-

philia, the deaf, especially deaf mutes, a considerable proportion of whose conditions are increasingly recognized as hereditary; and the blind or those otherwise hopelessly crippled, who are so handicapped as to be unable to support children. Yet many of these could have happier and larger lives if married.

TABLE V

MEDICAL INDICATIONS FOR GIVING CONTRACEPTIVE ADVICE IN CLINICS

From Records of 668 Patients in Out-Patient Services, Under the Committee on Maternal Health (N. Y.) and the Bureau for Contraceptive Advice, Baltimore

Main Reason for Giving Advice	Number			Per cent		
	Total	Committee on Maternal Health Clinics	Bureau of Contraceptic Advice	Total	Committee on Maternal Health Clinics	Bureau of Contraceptic Advice
Total	668	500	168	100	100	100
Gynecological and Obstetrical	236	151	85	35	30	51
Cardiac	132	120	12	20	24	7
Nephritis and Hypertension	89	75	14	13	15	8
Nervous and Mental	66	50	16	10	10	9
Tuberculosis	61	48	13	9	9	8
Syphilis and Gonorrhea (of either parent)	17	12	5	2	2	3
Eugenic	5	3	2	1	1	1
All others specified	44	38	6	7	8	4
Not specified	18	3	15	3	1	9

The accompanying Table V shows the distribution of the chief medical indications in 668 cases. These are made up from records of the first 500 patients admitted

to the nine hospital services in New York City under the auspices of the Committee on Maternal Health (C-5) and the first 168 patients admitted to the Baltimore Bureau for Contraceptive Advice. (B-38) All of these clinics receive patients for health reasons only, and on medical reference. Only the main reason is here drawn from each case record and the figures are arranged first by total instances, and second by per cents. As the figures are received from an increasing number of places, it is found that these proportions prevail.

The Table shows that on the average, one third of the patients were admitted because of obstetrical or gynecological difficulties serious enough to require postponement of pregnancy or to preclude it, while the rest presented non-pelvic contraindications to pregnancy, mainly cardiac disorders, nephritis and hypertension, tuberculosis and mental and nervous diseases.

The largest single entry under obstetrical and gynecological, was "*Multiparity*" meaning either many pregnancies or a rapid succession of deliveries, or both. Thus in the Baltimore series frequent entries occurred of women bearing "six children in six years," "ten in sixteen," "eleven in thirteen," or "twelve in sixteen" years. Most of these cases of multiparity presented other conditions as complications, increasing in number with the degree of parity. In this series the number of pregnancies ranged from one to twenty-two, while fifty per cent had had six children in twelve years of married life. As maternal and infant mortality both increase with the number of deliveries and with a lessening of the interval between births, limitation and spacing are both indications for routine contraceptive therapy.

It is significant that unattached clinics have a far larger proportion of obstetrical and gynecological cases than the hospital services, indicating one point of superior usefulness of the unattached centers in attracting women who do not seek regular hospital care for non-acute conditions. The hospitals have correspondingly larger proportions of cardiac and renal conditions.

In this connection it may be noted that other general and pelvic indications are found to be more numerous according to the number of pregnancies, this condition indicating the trend of events toward those revealed by mortality statistics, whether prenatal, maternal or infant.

Other pelvic indications specified are: serious degrees of malposition of the uterus, injured or deformed pelves, recent plastic operations, cystocele or rectocele, marked erosion, or tubal and ovarian infections; histories of repeated dangerous pregnancies with such symptoms as toxemia, pernicious vomiting, eclampsia, puerperal insanity, and paralysis; and such terminations as prolonged or difficult instrumental labors, or Caesarian section; and followed by serious degrees of varicose veins, perineal or cervical lacerations. Many of these conditions call only for postponement of pregnancy.

Closely associated with these gynecological and obstetrical conditions, and classified with them in the Baltimore report, are cases of general debility, anemia, asthenia, and malnutrition, where there is no overt disease nor even a distinct pathological entity, but where the whole picture is one of low tone, and a bad outlook for pregnancy.

Cardiac disorders, especially with decompensation pres-

ent or threatened, are generally accepted as indications for preventing or postponing pregnancy. Nearly a quarter of the cases reported by the C. M. H. Clinics were cardiacs, though these constituted only seven per cent of the Baltimore cases. This is found to be the single most frequent reason for asking birth control advice before any pregnancy has occurred. In one clinic a third of the nulliparae applying did so because of heart trouble.

Nephritis and Hypertension come next, and though small in number they are a highly significant indication. One reason for their relative infrequency in the unattached Baltimore clinic (eight per cent as compared with fifteen per cent in the C. M. H. services) may be that in general practice they are not discovered in time for reference, whereas their care is a matter of routine in a hospital service with good follow-up.

Mental and Nervous conditions included neurasthenia insanity, or feeble-mindedness of the mother, or such serious nervous disorders as epilepsy, post-encephalitism, brain tumors or paralysis. They formed one in ten of all admissions. Where these conditions are found in the father or as part of the family history they are grouped under "eugenic." Birth control clinics are not equipped to carry out sterilization operations though these are required in many of these cases in place of simple contraceptive treatment. Provision should be made for referring cases needing the more radical care to hospitals.

Tuberculosis was reported as a cause in only nine per cent. This may be accounted for by its widespread recognition as a contraindication for pregnancy. The bulletins of the New York State Department of Health include

a specific warning against pregnancy before complete recovery, though omitting to inform the patient about sources of help. Hospitals are beginning to recognize the importance of giving preventive care in this regard, and at least one large sanitarium is providing for contraceptive advice for its discharged women patients. A report on a group of nearly five hundred married women discharged from another of the great sanitariums in the state showed that forty per cent had never been pregnant at all. This is three times the proportion of involuntary sterility for the general population. Those that did report pregnancies had relatively few.

General Comments. This table shows only a single main indication for each case. As a rule applicants present several conditions requiring attention, and in some cases no single one may constitute a sufficient cause for contraceptive advice, though the combination does. The records of one clinic averaged three entries of positive findings per patient.

Contributing factors in the general health picture are age, numbers of living children, the physical and mental condition of the husband, housing, occupation and other social and economic features indissolubly bound up with the purely medical consideration. These items are entered in all the clinical records here and abroad, and it is shown that on the average the women are over thirty years old, have been married ten years, and have about three children living. Incomes are low, many patients being on the border line of dependency, and recruited from the ranks of unskilled labor. A large proportion of the mothers are gainfully employed outside the home.

Under the present New York State restrictions to overt medical indications one third of all the applicants to the Birth Control Clinical Research Bureau are turned away because they present "no health reason" though there often exist well defined strains on health such as long unemployment, overcrowding, or chronic alcoholism of the husband.

The physician concerned with preventive medicine is bound to consider whether it is sound practice to wait until oppressive conditions have broken the mother's health before help is given.

THE ENLARGING FIELD FOR BIRTH CONTROL CLINICS

The neglected parts of complete diagnosis and treatment, social and medical, found in the present practice among women who gravitate to birth control clinics are: premarital examination and instruction, as in the engagement period; conjugal maladjustment; sterilization of those permanently incapacitated for child bearing; relative sterility and an occasional grievous situation that raises the question of the need of a new study of the indications and justifications for abortion.

STERILITY. The diagnosis and treatment of involuntary sterility is a natural and interesting part of control of fertility and of the specialty of diseases of women and of obstetrics. The diagnostic work and the simpler parts of treatment may be bracketed with birth control when this service is housed in out-patient departments. And in any case the birth control clinic may serve as a clearing house and referring station.

The outfit for a start on the study of sterility is not ex-

pensive, but the full study involves specialities such as that of disorders of men, as well as the X-ray, metabolism tests and general health examinations,—and these are not available in the detached birth control clinic. In sterility study the male is first considered. It is, or soon will be, classed as malpractice to start treatment or complex examination of the woman, until the simplest of tests shows the male to be making his normal contribution.

Sterilization. In time the method of permanent protection for women permanently disqualified for childbearing will be minor operating and will not hospitalize the patient except where other surgery needs to be combined with sterilization. Then this may fall into the enlarged field of the birth control clinic, always provided that the proper formal safeguards and consents are built up around the measure. At present sterilization of the male is an "office" operation. As with sterility, the birth control clinic may appropriately serve as a referring station.

The Health Examination Feature. One unexpected development in the chief birth control clinics turns out to be of large present value and wide future promise. Women come for spacing of children or general health protection and then the pelvic examination which is required in order properly to advise on control of conception, uncovers a surprising amount of disorder, sometimes unsuspected. On this score alone the birth control clinic has already justified itself as a factor in preventive medicine. Many women with minor symptoms or none are found to have considerable injuries from childbirth, which would end in prolapse if not repaired; or disabling displacements or sacro-iliac trouble; or certain areas that call for healing

—areas which, neglected over long years, would foster cancer.

These findings are a very positive affirmative answer to the question sometimes raised, whether relatively complete local examinations are desirable. Thus it is that clinics become important reference stations whereby many troubles will be detected in their earlier and more remediable stages. Even the rather superficial general physical examination, if done by a careful observer, and accompanied by a review of the main items of history, may result in worthwhile discoveries.

Routine provision for securing the necessary care should be made part of the regular clinic procedure, and not left for emergency adjustment. Follow-up will be found surprisingly rewarding in this class of work, because of the favorable psychological situation that obtains. The patient, with a lively appreciation of having been helped by the doctor, in a way she understands, will be more than usually likely to carry out recommendations along other lines. This is a fact of practical importance in a preventive health program for women who are, on the whole, unwilling to exert themselves about their physical condition, but worry along without attention, often till too late.

CONJUGAL HYGIENE

We have faith to believe that out of the present limited and emergency service called the birth control clinic there will grow a department of *conjugal hygiene* whose function, largely preventive, will extend over a wide range of needs, and ages, to include:

(a) Sex education for adolescents
(b) Engagement and premarital counsel and examination
(c) Conjugal adjustment, and control of fertility as a part thereof

Conjugal hygiene is a wide field, a specialty almost untouched, but one which is to make a definite place for itself in the future. Only sketched out in Germany during the past decade, the *Eheberatungsstelle* or marriage advice station is sure to round out its place in health centers and university clinics, and several beginnings in America are under way. Whether or not governments demand certificates before marriage, as some now do, or whether they merely penalize or annul marriage of the diseased and the insane, as some do, public opinion should be developed and customs settled by experimental service before requirements are crystallized into code. (D-18a)

What the college graduate is now demanding commonly in the way of premarital examination will be asked by the women of the whole people in time. What the practice of health examinations will have inculcated will eventually be applied to the crucial time before marriage. Indeed, it is to be supposed that before the engagement is announced, certain simple major questions of fitness will be taken up, and before the wedding day is set, physical suitabilities will be settled.

In all these matters the program of childbearing will come up, the planning for the largest number of desirable children that can be reared by the particular couple. When sex sense enters sex education, early marriage will be fully discussed. As part of this problem, the spacing of children and control of conception become major considerations. In all marriages whatever, except a mar-

riage where both partners are ascetic, sterile or impotent, birth control and the mechanism of love loom large as techniques of happiness. Honoring all honorable acts of love means teaching them. Herein Nature is no better guide than in other works of art. No act of life is without a technique of training. By means of carefully developed teaching centers, sexology will get its place in the sun, instead of in the dark or in the limelight.

Thus we can look forward to a time not far distant when instruction in the technique of the control of conception will be only one section of marriage advice service, with close ties for frequent consideration with several specialties, among which are internal medicine, neurology, psychiatry, endocrinology and urology, not to mention the related fields outside medicine, of psychology, sociology and education.

The *marriage councils* will be staffed by men and women who are successfully married, normally sexed, high minded, clean minded, open minded and unhampered by inhibitions or by celibate dogmas.

The medical profession cannot with good grace object to laywomen and laymen starting birth control clinics and studies or marriage councils wherever and whenever physicians refuse to take the initiative. This is a movement for protection of women, and by women it is naturally undertaken.

PART TWO

SOCIAL IMPLICATIONS OF BIRTH CONTROL

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CHAPTER VII

LAWS, CUSTOMS, AND OPINIONS

THE present and historical standing of birth control is surprisingly well supported notwithstanding certain adverse laws and many loudly adverse opinions.

This chapter will give the legal status of contraception; a summary of the customs of different peoples in limiting their numbers, as distinguished from both laws and precepts; and, finally, a sort of census of the opinions held in the various fields of religion, ethics, sociology, and particularly medicine.

The final chapters in this section will discuss in some detail the results to society to be looked for from birth control.

I. LAWS AND GOVERNMENTAL ATTITUDES

In most countries birth control encounters no legal difficulties, though it receives no government assistance.

GOVERNMENTAL AIDS. The commonwealths of Mexico and of the United States of Soviet Russia; the cities of Vienna, Berlin, Dresden, Hamburg, and Frankfurt, and Aberdeen (Scotland); and the counties of Alameda and Los Angeles, in California; the state of Colorado, and (according to hearsay) Canton in China, all spend money to instruct certain of their citizens in birth control, for reasons of public economy or public health.

The Department of Maternal and Child Welfare of the

Russian Government publishes an annual medical report on proper birth control methods which is sold everywhere in Russia for about ten cents. The Moscow city obstetricians (official under the Soviet system) passed a resolution declaring that "a physician should instruct his women patients in birth control methods whenever pregnancy is at the time incompatible with health or otherwise undesirable (for instance for economic or social reasons)."[1]

The Mexican Government has printed the second edition of 100,000 of its birth control pamphlet, according to information received from Miss Mary Winsor, who visited Mexico City in March 1927.

At Los Angeles the County Outdoor Relief paid for birth control materials for 21 women prescribed for at the Mothers' Clinic in 1925. Now the County Health Department, in charge of a large number of towns in the county of Los Angeles, runs welfare stations giving birth control advice in nine places. In other parts of California and in Ohio, New York and Colorado, public money has supported clinics, as listed in Table I.

In Aberdeen, Scotland, with its population of over 160,000 the Center is "established under the auspices of the official Mother and Child Welfare Committee of that city." (S-14) A report by the United Press Nov. 9th, 1929 says Dunfermline Parish Council halted unemployment relief to a consumptive couple refusing to use birth control.

In the large cities of Germany, some of the official Eheberatungsstellen (Marriage Advice Stations) refer pa-

[1] Professor Peter Tutyshkin of Moscow Health Department (P-15, vol. I, p. 109).

tients to gynecologists for birth control advice, and some of the Sexualberatungsstellen of the "Bund" are official, while others are housed in public buildings, as are Johan Ferch's in Austria. (See Chapter I)

The British government permits the officials of its health centers to arrange for contraception on medical grounds only. (F-5, p. 32)

Governments with Neutral Laws. A large number of governments take no legal stand on this subject one way or another. Administratively some of them are neutral, while some assist the work. Fuller's "International Handbook of Child Care and Protection" (F-5), compiled from official sources, with a foreword by Grace Abbott, is attempting to make inquiry of all its correspondents in every part of the world on the subject of contraception. In the 1928 edition we find twenty-three governments stated to be without laws against birth control, if advertising bans are excepted, namely:

Albania
Australia
Austria
Belgian Congo
China
Danzig
Denmark
Egypt
Esthonia
Germany
Japan
Latvia
Luxemburg
Mexico
Netherlands
New Zealand
Norway
Russia
South Africa
Sweden
Switzerland
United Kingdom
United States of America (twenty-four states)
Zanzibar

A careful study of this volume suggests that, when all are heard from, the number will be raised to nearly forty

independent governments in the neutral list, plus thirty-six of the British minor colonies, together with such states of the United States of America as one decides to include. In making this estimate of forty independent governments not opposing birth control, I include no further Roman and Greek Church countries than those already specified in the preceding list.

Latin and Greek Orthodox Civilizations

In accordance with the teaching of her ecclesiastical authorities (F-5), contraception is forbidden by the Greek Government, except for reasons of health.

An Italian Commission under the Minister of the Interior was appointed about April 23, 1926, according to a press dispatch of that date, to investigate and act against birth control, Mussolini declaring that "a large family is . . . the most powerful instrument for Italy's inevitable expansion in the world." He later states that the birth-rate of several Italian provinces has fallen below that of France. (Associated Press Dispatch in Philadelphia Public Ledger, May 3, 1927.)

On July 31, 1920, France passed one of the most repressive laws made there since the Revolution. According to this, "anyone who by one of the methods numbered in Article 23 of the law of the 29th of July, 1881, should have devoted himself to a propaganda against childbirth," shall be subject to a fine of 100 to 5,000 francs and imprisonment for a term of one to six months.[2] By this law all

[2] See Marie Stopes' complete translation of the law (S-23, p. 361) and G. Hardy's important seven-page article (P-15, vol. I, p. 39).

meetings to discuss birth control theories, and all organizations as well as all practical work have been discontinued. Nevertheless, books such as Stopes' "Contraception" sell freely, though at an advance over the ordinary price.

Belgium, Poland, Lithuania, Portugal, Costa Rica, Colombia, and Chile are other Catholic countries with restrictive laws. (F-5)

Germanic and Scandinavian Countries

The laws in Scandinavia seem to be silent on the subject, and they are almost so in Germany. But we were told that the law of the Deutsches Reich against exhibiting and advertising contraceptive articles "for unchaste and lascivious purposes" (Paragraph 184, Absatz 1, Ziffer 3) has been efficacious in keeping wholesale druggists from sending catalogues listing contraceptives even to physicians. (R-7) (M-9) (F-5)

In Norway "there is no statutory prohibition of the teaching or practice of birth control *per se*, but it is generally held to be prohibited under the statutes dealing with indecent publications and articles." In Sweden "it is an offense against the Penal Code to expose for sale or to distribute any objects having for their purpose the limitation of families." (F-5, p. 316 and p. 357)

These laws have not generally been applied in a way to penalize physicians of good repute who may prescribe contraceptives, and many gynecological clinics prescribe them. (S-19) However, it is said that Dr. Nyström was heavily fined some years ago for lecturing on the subject. (A-4)

Legal Obstacles in the United States

A number of summaries of the anti-contraceptive laws in the United States have been made. (S-23) (W-11) (R-9) (S-12) (D-16) (D-12) and (F-5) Recently Goldstein and Goldstein, Attorneys, of New York City, have prepared a digest for Mrs. Sanger's Committee on Federal Legislation. For this, address Committee at 17 W. 16th St., N. Y. C. However, as is usual with the millions (S-9) of laws in our beloved but legislatively unfortunate country, many of them are so framed that they must and can be flouted with impunity. Thus, *what the laws say* in each state is of rather less practical import than how the judges and prosecutors, acting with the knowledge of public opinion, decide to interpret them, or whether they decide to ignore them altogether. We shall not, therefore, restate the seven summaries referred to above. In one or another of these, one can read that California, Pennsylvania and New Jersey have restrictive laws—yet there are eighteen birth control clinics now publicly running in these states. On the other hand, Worthington names New Hampshire, New Mexico, North Carolina, Indiana, Wyoming, and Iowa as states in which the physician is entirely free to offer contraception if he wishes (W-11, p. 465), but not one of these states actually has a clinic so far as we know.

Any summary is necessarily most inadequate. What is, from a practical viewpoint, the matter of most importance as regards state laws; namely, the interpretation put upon the *physician's position* by state courts and anticipated by important law firms, has not yet formed the subject of any systematic study. However, the law firm of Thomp-

son, Hine and Flory of Cleveland have assured physicians of their liberty in Ohio, and in the opinion of the law firm of Smith and Percy of St. Louis, Missouri should also be added to the list so far as oral advice to a patient is concerned. In the same way the physician is presumably free in Massachusetts.

The stringent postal and customs laws of the Federal Government (see especially Ref. D-12) comprise sections 102, 211, 245, and 312 of the Penal Laws and section 305 of the Tariff Act of 1922, with maximum penalities of five years in jail or a fine of $5,000, or both. *These laws prohibit interstate commerce in, and importation from abroad or mailing of, any information on or material means for preventing conception.* These laws are of course habitually broken, especially as regards interstate commerce in contraceptive materials.

Court Decisions in the United States

It may be said that the courts are moving favorably to birth control, if at all. There are no unfavorable decisions of as much significance as the following favorable decisions:

(a) By Justice Cropsey of New York (in the People, etc., vs. Byrne, 99 Misc. 1), permitting a physician to prescribe birth control "if in his opinion, the health or condition of the patient required it."

(b) The well written decree by Judge Harry M. Fisher in the Circuit Court of Cook County, Chicago, November 23, 1923, in the People of the State of Illinois, etc., vs. Wm. E. Dever, Mayor, etc. (General No. B 102638)

(c) By the United States Supreme Court, May 2, 1927,

favoring, not birth control, but sterilization, which involves some very similar principles.

(d) In the Municipal Court of Boston, Massachusetts, on March 1, 1928, when Dr. Antoinette F. Konikow, who had shown contraceptive devices during hygiene lectures to her women patients and their friends, was acquitted of "exhibiting" within the meaning of the law—that is, in the judge's opinion, of exhibiting for advertising or sales purposes. (E-2)

A certain man in California, who divides his time between his skilled trade and selling contraceptive pamphlets is repeatedly arrested and repeatedly let off by the judges, especially in the superior courts. (B-25)

In 1929 the police raided the Clinical Research Bureau in New York and arrested Dr. Stone and four assistants. The case against her was dismissed by the Magistrate, and public opinion was so aroused that a serious demotion resulted for the person responsible in the Police Department. (D-16)

A list of twenty-two trials under Federal Statutes is given by Mrs. Dennett (D-12, p. 47, p. 279). Seven trials resulted in no penalty; eleven in either a $25 fine or thirty days in the workhouse, or less; one in a $100 fine; two in sixty-day sentences; one combined a $1,000 fine and costs with six months' imprisonment. Two of the heaviest sentences were both passed upon Dr. Ben L. Reitman, the first in New York, the second in Cleveland. (B-8) The latter convictions are the only ones I have ever heard of against a medical man, and Dr. Reitman appears moreover to have thrown himself liberally, whether mistakenly or not, into propaganda rather than to have

been following the quiet practice of his profession, for we read that he had also been tried in Oregon as well as in New York and Ohio. It does not appear to be the policy of the states nor of the United States to interfere with any medical man in the ordinary practice of his profession. Nevertheless, medical men's fear of the Federal postal laws has sufficed to keep them from publishing in any American books technical details of contraception except Dr. Cooper's volume of 1928, (C-8).[3] Nor have they written very freely in their periodicals, although some articles have been published in the gynecological magazines such as the *American Journal of Obstetrics and Gynecology*, and in the *Medical Journal & Record.* These and the English medical journals; for instance, the special number on contraception issued by the *Practitioner* in July, 1923, circulate through our mails without interference by the Federal Government.

British Empire

Canada has no provincial laws against contraception unless it is in Ontario (R-9, p. 48), but the Dominion has a restrictive postal law.[4] Australia forbids the circulation of birth control literature. (B-12) Great Britain is

[3] Dr. Cooper's book is the only conveniently available source in America for medical details, and was the first book written in English by a physician.

Dr. Dickinson, Secretary of the Committee on Maternal Health, who sent out reprints in 1924 on technique to doctors, has another such book as Dr. Cooper's in preparation, which will present *moot* points yet more exhaustively and will in general deal with the frontiers of scientific study in this field.

[4] Birth Control Review, March, 1924, p. 72.

entirely free except that the Ministry of Health has refused, when asked for a pronouncement that no official medical center or officer will suffer administrative disfavor or loss of appropriation because of having given contraceptive information.

The women of the Labor Party at their annual meeting, 1927, at Huddersfield, through their 850 delegates voted very heavily in favor of the Ministry of Health's allowing contraceptive information through these public channels. A similar vote was cast later by the Liberal Party women. The men of the Labor Party hold out against it through fear of alienating the Catholics, the vote at the Annual Conference of the Party in October, 1927, being 2,885,000 against and 275,000 for birth control.[5] The House of Lords has endorsed the giving of birth control advice in welfare centers, but the Commons rejected this.[6] The Conservative Party and the men of the Liberal Party have not as yet committed themselves.

The Roman Catholics are credited by the press of Glasgow with having recently lost four or more municipal seats on the issue of birth control; in Salford they lost seven in the same way. (B-21) (B-18) (B-5) (P-9)

The Irish Free State recently passed one of the most unfavorable laws possible.

[5] On October 12, 1926, the rank and file of both men and women had repudiated by a narrow margin, 1,656,000 against 1,602,000, the official contention that birth control should not "be made a political party issue" (See the Birth Control Review for May 1927, p. 153, also for November 1927, p. 306). The opponents have also urged that birth control may become compulsory and an additional means of class control by the upper class.

[6] According to press reports for April 28, 1926.

II. THE STATUS OF OPINION VERSUS CUSTOM

Public opinion is of far greater weight practically than legal status, which is after all only the pale reflection of opinion.

In simple societies opinion is probably identical with custom; in more hypocritical groups, it may differ from custom and practice either in the same individual or in different social strata. It would not perhaps be too much to say that during the last two centuries moral condemnation bestowed by the unmarried clergy upon contraception and the custom of using it among the married have grown step by step and side by side.

Of opinion adverse to contraception among the married, we may generalize as follows—it is not inherent, but appears only where built up by Chinese, Hindu, Hebrew or Catholic religious teachings. The custom of limiting population on the contrary is inveterate, contraception only taking the place of other methods of limitation.

Abortion versus Contraception

One presumes that where a society approves of abortion, it would also practice contraception as fast and as far as the means became known. The two subjects are indeed in one sense closely connected; in another sense a profound abyss separates them. It is in the world of biological and economic thought that they are connected. In the world of Christian morals they are separated.

In this moral world, abortion is often labelled manslaughter, and is pardonable like any other manslaughter only under strict conditions and for high ends; while, on the contrary, preventing the start of a new being is at

least a debatable subject and is permitted even among Catholics by the so-called natural method of abstaining from relations during part of the menstrual month. A delicate-minded and morally developed person who attempts to enlighten his friends or the public on birth control grows weary and disgusted with having to preface his remarks by an explanation in words of one syllable of this distinction between manslaughter and prevention. He feels that everyone should readily perceive this abyss of moral difference.

But in the biological struggle for existence there is not this abyss. The plain fact is that an abortion, a contraception, and a death of some member of the existing population are three numerically equal ways for achieving the same end: one less mouth to feed on an amount of material resource sufficient for those already existing, but not for one more. Thus it appears to be a deep and true biological instinct in the populace which associates abortion and contraception and thinks you include the former when you speak of the latter.

Indeed, abortion is at this moment a definite constituent of our economic state.

The fact is that if hundreds of thousands of abortions had not occurred in our country in the past year of grace, the population pressure would after a few years have become, and would have been sensibly felt as, considerably greater than it now will become. Indeed, a number of coming marriages among our people, especially the more provident, would have had to be postponed for years, if not entirely. School taxes and poor rates would have had to have been increased during the next decade and the

pressure would inevitably have been felt by some. "We are all members, one of another" in modern states which feed and educate all who can not do it for themselves. To exchange these hundreds of thousands of annual abortions for an equal number of living children would penalize every one very heavily indeed in their purses. These pregnancies must be prevented from the beginning.

Let us proceed to the analysis of how various societies distant from us in time or development have regarded the dilemma of population pressure.

Customs in Diverse Cultures

It is not too much to say that the most arresting contribution to population problems since Malthus is the doctrine of the conscious control of population throughout the world and throughout history. This is first adequately treated in the chapter by Sumner the American sociologist (S-26), in the first fifteen pages of Theilhaber the German (T-3), and in the later massive work on the same subject by Professor Carr-Saunders of Liverpool.[7] (C-2)

Carr-Saunders shows that Malthus' checks of war, famine, vice and plague have never been at all adequate to keep population within the bounds of the available re-

[7] See review of Carr-Saunders' *Problems of Population* by Prof. James A. Field (Chicago) in the Journal of the American Statistical Association, December 1923, p. 1051–3, and comment by Walter F. Willcox in the same periodical for June 1923, XVIII, No. 142, p. 700–712. See also Yule's review Roy. Stat. Soc. July 1922, pp. 626–9. In "A New Contribution to the Population Problem," *Economica*, June 1923, pp. 122–132, Morris Ginsberg, professor at the University of London, says this book is "by far the most important review of what is known on human evolution."

sources of food, etc. These authors all agree that *other deliberate and (at the time) socially approved efforts are the rule* in nearly all ages and places; namely, abortion, or infanticide, or celibacy, or homosexuality, or prostitution or late marriages, or contraception. Carr-Saunders' work is supported by references to about 800 other works. No one can read his scores of pages which describe infanticide and abortion in every age and clime without being profoundly impressed with the terrific problem which besets mankind. The reader who has looked to birth control to solve the problem of poverty is especially likely to have his views modified. If mankind has been limiting its offspring from prehistoric times onward, then the invention of modern contraception may not be a really new solution to the problem of poverty, so far as this in turn depends upon population. Rather, contraception is essentially a new and superior substitute for abortion and the other repulsive practices which have always existed.

Biologists and anthropologists are not generally surprised at these views concerning the conscious efforts that have always been made to limit population. Thus anthropologists may be found arguing whether here and there among each group of tribes one tribe may be listed as actually failing to sanction and practice habitual abortion or infanticide. (A-3) (S-26, sec. 322) Similarly, the historians of morals may be found arguing as to how far during the Middle Ages celibacy and late marriage, aided of course by Malthus' three checks, were able to deal with this eternal difficulty without the aid of the early barbarous practices or the modern contraceptive discoveries. Sumner's "Folkways" says of Europe: "Through the Mid-

dle Ages . . . the custom of exposure continued. The primitive usages of the Teutons included exposure of infants." (S-26, sec. 327)

The Handwörterbuch der Staatswissenschaften has an astounding account of later efforts, mostly governmental, to prevent or postpone marriage in Germany, especially during the post-renaissance and post-Napoleonic periods of financial depression. Marriage was hindered among government officers in Bavaria by a government ruling of November 15, 1896 (S. 332), and elsewhere in Germany in 1913, if not now. (E-7) (T-3, p. 95) (M-5, p. 255)

On February 13, 1928, according to a press dispatch of the same date, marriage was forbidden to Polish army officers below the rank of captain unless able to give bond that they had private means.

Survival of Primitive Means of Limitation

It is to Germany that one must go to find in a highly modern nation indications of the pressure of population similar to those found among more primitive peoples. Is not this to be explained geographically? The greater part of Germany is in the center of Europe and has not had the outlet overseas for surplus population which the Viking fringe to the northward has enjoyed for a thousand years, and the Dutch and English for four hundred years in their great overseas dominions.

How else will one explain the fact that the German race, which has been able to develop so much in the realms of music, artistic crafts and science to divert it from purely sensual living, has remained more cynical than the Dutch and English about sex-morality, has had a much higher

illegitimacy rate (R-3), a higher infantile mortality rate (U-1, p. 31), laws limiting marriage such as are unknown amongst more western nations, and a lower status for women? Why is abortion so pressing a problem that large groups of humane people press openly to have it made legal for all cases? These are questions which have exercised my mind for twenty years.

It appears that its difficult geographical situation has given Germany a pessimistic psychology on the population question causing it to be backward in developing modern attitudes toward women and child-bearing and slow in replacing with something better the old savage devices of abortion and infanticide, and illegitimacy, which so often results in the child's death that it may be considered a sort of modern infanticide.

Early Contraception

Contraception is not entirely modern, for Carr-Saunders' painstaking survey shows it in full use among South African and German East African and Congo savages, and to a slight extent among savages of the Pacific Isles. (C-2, p. 177, p. 187) Theilhaber (T-3) gives some particulars of its use among the ancient Jews, the German tribes, the Arabs, the Franks before their conversion to Christianity, the Greeks, and the Romans. Both Plato and Aristotle admitted that their ideal state should allow abortion, so it is not surprising that no later classic writers voice an objection to contraception, a substitute so much less objectionable.

Carr-Saunders quotes Sutherland (*Moral Instinct*, Vol. 1, p. 139) on the Burgundians, Saxons, and five other simi-

lar tribes, who, before their conversion to Christianity, probably practised abortion, since afterwards enactments against it were necessary. (C-2, p. 257)

Thus the primitive world in general is seen to have been obliged to hold down its numbers, sometimes by contraception, but more usually by repulsive practices against which protest was made by the great religions as fast as they developed. But while religion has changed the ideals, it has been much less successful in changing the practices of the people, and least of all in those countries where the pressure of population has been most keenly felt. Abortion has reversed itself and become a crime instead of a moral obligation as it was among many tribes under certain circumstances, but it is nevertheless still practised.

Prevalence of Abortion Today

Medical usage now limits the use of the word "abortion" to expulsions occurring in the months before viability whether legal or illegal, and discards the term "miscarriage" entirely; and "still-birth" is the delivery of a dead fetus at any time between viability and term.

The minimum estimate by physicians of the prevalence of abortion in modern countries is one in every ten or twelve pregnancies. (R-3, p. 130) (F-3) (T-2) (A-2). On the other hand, many estimates are in the neighborhood of one in five. The classic figures often quoted in the United States seem to be the 1881 investigation of the Michigan Board of Health:[8] that one-third of all preg-

[8] This is quoted in (F-3) (P-6) and (T-1), and the same figures appear in Peterson & Haines' *Textbook of Legal Medicine and Toxicology*, vol.

nancies end in criminal abortion, with 6,000 women dying annually in the United States as a result. Devilliers is quoted as believing one pregnancy in three or four is "interrupted." (A-1) Today physicians not writing on abortion, but needing the figures for quite other researches, calculate that thirty per cent of the conceptions fail of a child. (M-29)

The 1921 meeting of American obstetricians and gynecologists gave special attention to this subject and Dr. Palmer Findley was of the opinion that one in every five or six pregnancies was interrupted, half of them criminally. (F-3) From this, one obtains a figure confirming the minimum estimate mentioned above for the deliberate rejection of excess fertility; namely, one in ten or twelve.

At the same annual meeting, Mr. Oakly, Prosecuting Attorney of St. Louis, having read a paper, was challenged to bring forward any case in which a midwife or physician was at that time in jail in Missouri for criminal abortion. He did not take up the challenge. During the discussion as to whether anything could be done to reduce these crimes there was much pessimism. It was cynically said that juries would not convict, as there was always at least one man of the twelve afraid that his own wife had trafficked with the particular abortionist on trial.

Another important session on this subject was that of the German Physicians' Convention in 1925. (N-5) Dr.

II, p. 92. Dr. R. M. Woodbury gives the following titles: Prinzing, *Handbuch der Medizinschen Statititstik*, 1905, having a number of references on this subject; Dr. Fred L. Adair and Dr. C. O. Maland, "Results Gained in Maternity Cases in Which Antenatal Care has been Given," Jour. Am. Med. Assoc., vol. 81, pp. 992–998, September, 1923.

Vollman quoted Bohn, the gynecologist, to the effect that 89 per cent of all interruptions are criminal, and Hirsch stated that in women aged thirty-one to thirty-six, 98 per cent of the interruptions are criminal, while at other ages only 78 per cent are. This suggests that these women of thirty-one to thirty-six years have already borne as many children as they feel able to rear and are taking these measures for reasons connected with a feeling of responsibility towards any child if brought as far as birth. If all abortions at all ages were equally dictated by shame and selfishness alone, then as many such crimes would occur in the twenties as in the thirties. At this same meeting, the miscarriages in Germany were estimated as being 400,000 in 1921, as against 1,612,000 births, a rate of one in five.

More sensational estimates have been made. Leroy-Beaulieu is said by Carr-Saunders (C-2) to give a very high rate for France in his *Question de la Population*, p. 330. Professor Lacassagne of Lyons, France, is quoted (D-25) as having found more abortions than births in that city. Dr. Max Hirsch quotes an opinion, though he does not state whose, that there are 2,000,000 annually in the United States, or a rate of one abortion for every two births. (B-9)

Popenoe (P-10) and Reuter (R-3, p. 130) give paragraphs of figures similar to those in the preceding paragraphs. Professor A. W. Meyers, of Johns Hopkins, summarizes the "estimates" as follows: voluntary abortion occurs in 10 to 30 per cent of conceptions. (M-23) Let us take the 10 per cent estimate, but emphasize that the significance of even this lower figure has been scarcely

realized at all by our thinkers and leaders. There is an excess of productiveness in the human race which results in at least 10 per cent of criminal abortions; in a certain unknown per cent of infanticides and other forms of welcomed infant mortality[9] and in further per cents of prostitution, suicide, and unhappiness for those single persons whom marriage might stabilize if it could be afforded. Sumner deplores the fact that many modern women (ten per cent in the United States) are condemned to single life. Within a century the situation has become much more acute through the enormous reduction in infant mortality.[10]

The Excess of Human Fertility

It is this great excess of productiveness (fifty per cent or more) continually working woe to the human race that has led neomalthusians to consider the advisability of separating marriage from parenthood in the cases where the latter cannot be afforded. Dr. William Allen Pusey, ex-President of the American Medical Association, has said of abortion: "The trade . . . cannot be extinguished . . . it is one of the tragedies of civilization which is most completely concealed, methods of birth control offer the only relief from this tragedy." (P-17)

At least we may say that monastic life and contracep-

[9] I was told in the office of a leading member of the San Antonio Board of Health that the Mexican laborer in Texas habitually rejects the offer of operations and all such medical aid for infant children.

[10] Ref. S-26, sec. 383. E. S. Ross speaks of reduced mortality and of a 67 per cent excess fertility. Meyers says 92 per cent! Prof. Henry Pratt Fairchild has three pages on this subject, which are exceedingly clear and forceful. (New Republic, Oct. 16, 1929.)

tion are the only devices which seem likely to end this primitive and still-continuing state of habitual arrest of life in the unborn, and near-murderous neglect of the new-born to the extent of at least ten per cent of the total children conceived. It is very significant that extensive monastic life *and* polyandry are both required in Thibet to keep the population from any increase there, where the hostile climate makes increase unthinkable, because sustenance cannot be increased. The Johns Hopkins professor (M-23) quoted above feels that "the size of the average American family implied that less than 80 per cent of the potential and probably less than half of the actual reproductive capacity of married women is realized." What would happen if the habit of controlling fertility should suddenly be abandoned, as some writers desire?

It is incontrovertible that abortion, and in advanced countries, contraception, have their established place among the customs of the nations, by which they manage to survive and maintain their standards of living.

Attitude of the Great Religions

As Mohammed condemned infanticide but not abortion (C-2, p. 257), one would not expect his followers to be opposed to contraception, and there is no evidence that they are.

By ancient Hebrew law contraception "except in cases of extreme youth, or illness of the woman, or in the case of nursing mothers, is forbidden." (F-5, p. 503) Nevertheless, the Jewish physicians in the United States have done more to aid organized clinics than any other body of people, and the liberal rabbis have given their official approval to birth control. (C-4) (S-31, p. 142)

According to typical Chinese and Japanese religious thought, to leave no posterity is supposed to be fatal to the soul. Nevertheless, when once a person has been provided with sufficient posterity we may suppose contraception is not frowned on, for we hear that it is practised, that infanticide is practised, and abortionists advertise their trade "on every bill-board in Peking." (M-12) (M-2)

Among orthodox Hindus it is a sin for a girl to menstruate even once before marriage, for thus the possibility of the incarnation of one soul is lost. (S-26, sec. 399) (S-23, p. 235) Of course, this position is antithetic to all contraception. This theology may be compared with the Roman Catholic position on contraception, which says that preferably no month after marriage shall pass with the wife unfertilized, except for grave reasons of ill-health, adultery, etc., or except by mutual consent of both partners that they will seek the alternate virtue of continence instead of the virtue of "increasing, multiplying and replenishing the earth." (C-9, p. 7, 8) It is apparent that the Catholic thought is much more systematic and well developed than the Hindu. The Hindus cherish and provide for the "alternate virtue" of chastity for men, but not so much among women. And they have not tried to deal with the over-population difficulty at all. The Catholics have provided convents for surplus women and confession and penance for women who commit abortion or practice contraception, while the Hindu system would simply condemn them without possibility of systematized commutation. At the same time, while these devices for keeping down population cannot be commuted by penance in a religion like the Hindu lacking an organized

clergy and regular monthly confessionals, neither can they be effectively fought. Hence, infanticide and abortion are rife in India, and contraception will spread rapidly when the population has enough money and enlightenment to obtain it.

As to China's future, one may draw what conclusions one can from the fact that Margaret Sanger's address to the University of Peking in 1927 was arranged by Dr. Hu Shih, voted one of the "twelve great men" of China and well known for his leadership in adapting the vernacular to the needs of a newly constituted popular press which had never existed before. (B-17)

It is only when we come to Catholicism, the only religion having had available for centuries such devices as the confessional with which to wage war upon abortion, and resources like the monastery, the convent, the foundling home, and the glorification of virginity by which to meet the population problem, at least in part, that a whole-hearted objection to contraception is to be expected. When a great organization has worked for more than a thousand years to meet a problem, it is not likely to welcome a new-fangled solution which will lessen the necessity for these vast and carefully-worked-out devices. Especially is this true when the new-fangled device is certain to result in lessened membership through lowered birth-rate and in loss of moral prestige to the whole system of exaltation of celibacy if the modern views of sex shall triumph. By this we mean the view that the sex life is in itself worthy and that celibacy for any person is in itself not unlike complete prevention of conception in married people; that is, in the main abnormal and undesirable.

Rome has been saying for over a thousand years: "God does not intend all men to bring up a family; some He calls to the religious life in monasteries and convents. He calls too on married people to practice continence at times, when they have not the means to bring up a family." The people have obeyed only in part; many of them as we have seen have persisted in the old and evil ways. Now the issue is joined between the best that Rome has been able to inculcate and the relatively new devices of contraception. The question is, which is the lesser of these two evils?—

The present amount of abortion, celibacy and prostitution
or
A less amount of each, plus contraception, plus a possibility of increase of extramarital intercourse

Catholic authors contend that celibacy is not even undesirable and that abortion would increase, not lessen, under a regime of contraceptive practice, in cases where the method accidentally failed, and that extra-marital intercourse would be greatly augmented. (C-9)

The other side holds that celibacy is an evil, contraception a necessity, and that abortion and extra-marital intercourse would be much less if every one were able to marry without fear of too many offspring, and if men were not turning to prostitutes because of their wives' fear of the results of intercourse. The problem of celibacy, being a matter of individual feeling and values, may never be settled; the problem of abortion, and possibly even that of extra-marital intercourse, will be nearer solution when we have good comparative statistics from communities which practice, and those which do not practice, contraception.

Certain dignitaries of the church have been quoted in the press as saying that birth control advocates are shutting the door in the face of troops of little angels whom God wishes to send down from Heaven. However, in the treatise written for the National Catholic Welfare Conference by Professor John M. Cooper of the Catholic University of Washington, D. C. (C-9), esoteric theological reasons seem to be entirely omitted and the argument of the treatise is purely ethical, although under the Catholic understanding of divine law, and is as follows (p. 80):

(a) The world is in more danger of under- than over-population, particularly by "the fit."

(b) There is sufficient wealth for everybody if only it were more justly divided.

(c) Births can be properly spaced by lactation, save in exceptional cases, and in them by continence.

(d) Hence, there is no excuse for resorting to contraception, which is innately shocking to conscience and which fosters egotism and prevents the altruistic development which comes more surely with the process of rearing many children than with almost any other discipline.

The reply to these points would run as follows:

(a) We can scarcely conceive of what the over-population of the world would immediately become if everybody from Thibet to France and America, should suddenly cease practicing the various forms of limitation of population (from polyandry to abortion and prostitution and contraception itself), which a portion of each nation is now everywhere following.

(b) Though it is true that a more equal distribution of income in the United States, as urged by the Catholics,

would give each family about $2,930 a year, it has never been determined what effect such equal distribution might have in substituting an increased birth-rate and increased consumption of luxuries for the present most necessary replacement of worn-out capital goods and endowment of education. Also, there is no sign of any such voluntary distribution taking place, and the question arises, is it not an ethical duty to *force* a more equitable apportionment by limiting the supply of poor laborers and thus commanding a higher price for their services?

(c) Births *could* be spaced by lactation and continence —enough for health, but not enough to hinder population pressure—if human nature were different from what it is. The Roman Church has had a millenium in which to alter our human nature, and having failed, might now be wise to add contraception to all her older devices for limiting population.

If doubts can be cast on points (a), (b), and (c), the conclusion (d) can no longer be so confidently drawn.

This authoritative pamphlet (C-9) has on page 7 the only reference to what has in the past been one of the chief recommendations of the church for controlling too large families; namely, use of the "tempus ageneseos," or continence during the earlier weeks of the menstrual month (P-13). Perhaps Catholic opinion is beginning to shrink from the dubiety of suggesting that people seek the holiness of parentage during that part of the month when it is of least avail to seek it, while during the rest of the month they foreswear what Professor Cooper calls the "degrading and degraded grossness and unloveliness" of sex passion (C-9, p. 17) just at the one time when it *might* be redeemed by the prospect of parentage. That is, the

observance of the "tempus ageneseos" only pretends to seek parentage and only abandons the "grossness" of sex at the exact time when it might hope to be "redeemed" by parentage. It is a pity that the Church cannot cease to feel the need of special justification for sex, and cannot quite bring itself to regard sex acts as being like unto any other acts; namely, neither good nor evil in themselves, but only in their consequences.[11]

Other Religious and Ethical Writers

While Professor Cooper's and Father Ryan's (R-11) economic arguments denying the over-population danger are regarded unfavorably by economists, their main contention that birth control leads to an egotistic life and to too small families has been supported in an official vote of the Anglican and American Episcopal clergy,[12] and by

[11] In a commentary on the present status of Catholic opinion, Dr. Drysdale discusses the public pronouncement on the venereal packet by Dr. Vermeersch, Professor of Moral Theology at the Gregorian University at Rome. (D-21) Dr. Drysdale considers that it will be difficult to maintain a position whereby abstinence is enjoined "on married couples who live in close contact and constant desire and opportunity for union, while admitting the impossibility of restraining men from yielding to chance temptation." The rejoinder by Professor Vermeersch and a counter-rejoinder by Dr. Drysdale appear in the Birth Control Review for January, 1929. See also "A Roman Catholic View of Sterilization," which is a review by Paul Popenoe of Joseph Mayer's learned book on sterilization (M-13), and the writings of Boyd Barrett. (B-3)

[12] At the Lambeth Conference of Bishops in 1920, the majority declaration of the English Church was against "unnatural means for the avoidance of conception," declining, however, to "lay down rules which will meet the needs of every abnormal case." This was endorsed in the United States on October 20, 1925, by the House of Bishops only, and not by the laymen, at the Triennial General Convention of the Protestant Episcopal Church.

students of ethics. A. D. Lindsay, Regius Professor at Oxford, writes with his wife a powerful article on the subject in the *Hibbert Journal* (L-3), and the same view is presented by the English Quakers in their discussion of "Marriage and Parenthood." (M-11) But in the end the Lindsays and the Quakers stand with general non-Catholic opinion. The Quakers say: "It seems to us that under certain circumstances the use of contraceptives in the marriage relationship may be legitimate." Nevertheless, a married couple seeking to know, at once, the *worst* that there is to be said of the moral and physical dangers in contraception, can scarcely do so more conveniently than by sending for this moderate and unbiased pamphlet. It must be understood that the pages about the physical hazards are merely repeating the generally unfavorable views current among physicians at that time, which have as yet failed of any confirmation from accurate, scientifically recorded instances.

Leading clerical proponents are: Dean Inge, of England, and in the United States the Rev. H. Adye Prichard, Dr. H. V. Darlington, Harry Emerson Fosdick, John Haynes Holmes and Rabbi Stephen Wise. (S-31)

Organized Censorhips. One of the chief forces opposing legal liberality towards birth control in America has been the New York Society for the Suppression of

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The Federal Council of Churches through its national committee on Marriage and the Home brought out a "Protestant Church View of Sex, Love and Marriage" which remands to a later report the question of birth control, concluding that "before a satisfactory statement can be made extended research must be undertaken." Cf. *Current History* Feb. 1929.

Vice—the "Comstock Society"—whose guiding spirit is now John S. Sumner. Nevertheless, he is strongly for contraception "where there is a probability of diseased or mentally defective progeny, or where the health or life of the mother would be endangered." (S-25) His attitude is that contraception under these circumstances can now be obtained in America without further legal changes. But this is not true. We may cite two instances among a single group of kinsmen since 1913: One mother living in a liberal Western state had eight pregnancies in the first nine years of marriage before her physician, a very liberal man and one of the leaders in that state, succeeded in his constant efforts to master the situation. Another mother, wealthy and highly educated, living near New York, conceived five times in four years, but found no physician willing to advise her. In one case, the medical profession lacked skill; in the other it withheld consent—yet in each case the repeated pregnancies constituted a menace to the health if not the life, of the mother. It will probably be many years yet before *poor* mothers in *illiberal* states are assured of protection against danger to health, or even to life itself, through untimely childbearing.

General Agreement in the Western World

The prevailing non-Catholic opinion among western nations is: *The use of contraceptives is right when practised by married persons for adequate reasons.* It may also conceivably be the lesser of two evils among the consistently abandoned. But who shall judge as to what the adequate reasons for married people are?—And how

frequently do they occur? The physician and the economist are well equipped to judge. We shall presently devote two sections to the opinions prevailing in these two professions. Biologists and professors of ethics might also be consulted. But whether or not these professions or others be the best judges, the non-Catholic western world remains content to let each couple be its own judge: witness that in most countries the drug stores continue to sell contraceptives whatever the law may say.

To my mind, the most significant vote ever taken on the subject of birth control in the United States was the ballot cast in its favor by one Section of the General Federation of Women's Clubs in America at the 19th Biennial Convention. The Section consisted of 500 persons, one third of all the delegates, and their unanimous vote shows what the vote of the whole convention might have been if the officers had not been fearful of the secession of the Catholic Clubs, and had allowed it to be taken at a full meeting. (D-12, p. 192) This was in 1920.

Birth control has also been endorsed by the following:

The New York State Federation of Women's Clubs, by 149 to 97 in 1920 (B-10), followed by the Pennsylvania Federation in 1928.

National Union of Societies for Equal Citizenship (British), in 1925 and in 1927 (B-16), The National Council of Women (1929) and many large groups of British women.

New York League of Women Voters, November 1926, by 52 to 42.

New Jersey Women's Republican Club, April 30, 1927.

The audience at a 1924–25 debate between the Univer-

sity of North Carolina and North Carolina State College, by 200 to 50.

The Universalist General Convention in 1929.

Too Narrow Opinion of the Propagandists

Most persons active in birth control work are so convinced that each normal couple should be its own judge as to whether there are serious reasons for needing birth control that they neglect the theoretical wrongness of birth control for non-adequate reasons. This is a pity, for it arouses against the movement many persons seriously interested in ethics and in eugenics. The opinion italicized in the preceding section is so conclusive that birth control people cannot afford to ignore, as they do, the last three words, which are what make it unanimous and ought to make it possible to get all needed legislation. When more birth control propagandists take pains to give sympathetic attention to this theoretical point the movement will be strengthened without any practical alteration in its workings.

Most propagandists will find little trouble in taking this theoretical position when they see that it amounts to no more than a protest—*though a very important one*—against emptiness of life. Just as no one ought to repudiate the very idea of marriage except for weighty adverse reasons, so no one should refuse to bear children except for proper reasons. So say the professors of ethics. When the propagandists shall make this gesture of concession to the science of ethics the birth control cause will have the non-Catholic professors of ethics universally on their side, as are already the non-Catholic professors of the social

sciences. The cause does not need to bid for the support of the multitudes of featherheads who practice birth control happily without a qualm. But it should answer fully "the still, small voice" of Protestant ethics which enormously aids the Catholics at present.

The Unloved Child

One "adequate reason" for birth control requires special mention, that connected with the right of the child to be wanted. If there is cause to think that the child will *not* "bring its love with it when it comes," then that is an adequate reason not only justifying, but requiring, contraception. The saddest sight in the world is a child unloved by its parents. As the causes of crime are studied, the unloved and misunderstood child stands out more and more prominently as a potential wrongdoer. The maltreated emotions in early life seem more often the pivot on which the whole life takes its swing towards crime than inadequate income or lack of intelligence. Thus in one of the latest of these studies (C-10) the statistical findings point towards the broken homes; the failure of institutions for children where the training in family emotions is wanting; the probably impaired relation of child and parents where the latter are recent immigrants or have too large a family. The numerical position of the child in the family is also found to have an effect. But on the contrary, income and grade reached in school show no correlation whatever. All this shows that love and understanding sympathy are the greatest determining factors in the life of a child.

Anti-Birth Control; Practical Effect

One may find many varieties of non-Catholic writers against contraception—often very bitter. (See Dell's important article, D-11.) But when one analyzes them there is commonly a sentence that brings them into line with the central statement which we italicised. They are willing to allow contraceptives for some adequate reason which appeals to them "in a country that is *really* crowded" or "for a woman who is *really* ill." But they do not say who is to form the tribunal on crowding, ill-health, and so forth.

The only parties needing serious consideration because really against all contraception are the Roman Catholics and the imperialists. If the birth control movement in any locality is hindered, it is chiefly by these forces. The National Catholic Welfare Conference in Washington, D. C. for instance, carries on an active campaign with speakers and literature.

Others, after they have had the movement explained to them, will either let it alone or will, in quite sufficient numbers, assist it. For instance, certain big manufacturers are an example of a group whose interests would suffer by any reduction in the supply of cheap labor through birth control or otherwise, yet who are ashamed to come out and fight it on this basis. Thus, the National Industrial Conference Board may point out that there is a "broader and more fundamental economic problem" involved in birth control than national health and biological and economic waste—namely, the maintenance of "a ratio of population increase sufficient for the productive needs of the nation" under present restrictive immi-

gration.[13] Yet when an individual manufacturer tries to stand on this ground in a town where a clinic is proposed, public opinion soon shames him into silence and inaction.[14] The whole spirit of the age is against such a philosophy, and he knows it.

If a sufficiency of the non-Catholic population does not rally to the cause in a given community, it is likely to be for the following reasons:

(a) Because the key men in the community fear to antagonize the organized power of the Roman Church (S-1) (B-5), which is often able to make or break politicians and educators, and likewise budding community projects.[15]

(b) Because many men in the community, key men and others, fear that their personal economic interests—such as the overseas market for their goods or their labor—are menaced by any movement directed against increase of population and hence against continued expansion of their nation into new territories. In other words, in every country the religious forces fight alone unless there is an expansionist-imperialistic group to help them. Denmark is a country in which the Catholic opposition is unsupported by other elements. (J-2) This opposition likewise stands alone in the United States because it is understood that any expansion of this country will not be due to over-

[13] National Industrial Conference Board, Inc., 247 Park Avenue, New York City, press release of April 8, 1925.

[14] Unpublished reports 1926–7 to the American Fund for Public Service.

[15] The periodical "Time" for February 4, 1929, attributes President C. C. Little's retirement from the presidency of Michigan University partly to resentment at his espousal of birth control. (See also Refs. S-1 and B-5.)

crowding. We are not expecting to conquer any South American nation, for instance, because masses of our population have been crowded out of our bounds into theirs! But in England and Holland where expansion into their empires overseas is a daily question in all practical politics, the religious opposition gets notable help from the imperialists. France and Italy are the other examples of union between Catholic and imperialistic interests on birth control, and the imperialistic influence is far from negligible in Germany.

But there is no doubt that the Catholics do have a great deal at stake in most countries. Popenoe and Johnson say: "Nothing can be more certain than if present conditions continue, Roman Catholics will soon be in an overwhelming preponderance in the Eastern United States, because of the differential birth-rate, if for no other reason." (P-11, p. 273) Catholic lay journals write thus. The official journals sometimes express a contrary expectation.

Near Unanimity Among Social Scientists

There are thousands of practical social workers in the United States and a great number of teachers of politics, economics and social work in our colleges. These great new professions are to some extent recruited from the sons of ministers and are supplementing the ministry as the intellectual and moral leaders of the people. The mass of their writings is voluminous. One may browse among their books and magazine articles for twenty years and scarcely come across a writer who is willing to sign his name to any condemnation of birth control as morally

wrong, or any suggestion that it is possible or desirable to go back to the pre-Malthusian days when contraception was not widely practiced. Many of course have written, not that birth control is wrong, but that it works out badly and must somehow be corrected to make it available for the less fortunate classes, so that the more fortunate need not bear the whole task of keeping the population within bounds, with dysgenic results to the race.

The compendium of articles (J-3) collected by Mrs. Johnsen, who does not advocate birth control, is typical; among her fifty-nine articles she has only nineteen negative articles, four by Catholics, one or two by men educated by Catholics, one unsigned, four by doctors, the one by Professor Lindsay, five or six by obviously unlearned amateurs, and, as far as appears, only one (Dr. Dublin's) by a social scientist or social worker.[16]

A word now concerning the only non-Catholic social scientists in the United States who have attacked birth control: Dr. Frederick Hoffman of the Prudential Life Insurance Company and Dr. Louis I. Dublin, of the Metropolitan Life Insurance Company. A high birth-rate is perhaps a matter of considerable importance in insurance.

In the Atlantic Monthly, Dr. Dublin writes against birth control (D-22), but in the opening article for his compilation of addresses (P-12) given under his presidency before the American Statistical Association, he is much less emphatic. He merely girds in passing at the people who want birth control *at a time* when in his pro-

[16] (Ref. J-3) The author declares her selection impartial, but herself unconvinced of the merits of birth control from any point of view until it can present a more conclusive case than she has been able to find (letter to C. H. R. June 24, 1927).

fessional opinion we are rapidly approaching a stationary population. And then he describes our chief necessity as being to check the reproduction of the obviously unfit—which position goes far toward satisfying the friends of birth control. Finally, in a third address before the Neo-Malthusian and Birth Control Conference itself, he is even more friendly, admitting that "there is undoubtedly a larger group [than that in which the health and life of the mother are in danger] to whom information may be extended with propriety. But how shall that group be defined?" (J-3, p. 253–263 and P-15, Vol. II) Thus he is back again in the fold with the rest of us: birth control is not always wrong, but often right.

We may note that in imperialist England and Holland, at least two highly placed social scientists may be found opposed to birth control; for instance, Dr. H. N. Methorst, head of the Dutch Census, and Sir. William Beveridge, of the London School of Economics which sits half-way between the palace of the King-Emperor and "The City," capital of the greatest business empire ever known. We recall again that an expanding population is a *sine qua non* of empire.

But for the most part the social scientists have now completed a century of reflection upon their master, Malthus, the inspirer of Charles Darwin; and their minds grow clear. The master has become no less impressive because proved wrong in certain of his prophecies. A century, or at least half a century, of contraception as an accomplished actuality, with a falling birth-rate and a rising standard of living such as Malthus had forever despaired of, is a great historical fact of our generation.

Family limitation has contributed to this miracle of raised standards. Consequently, social science no longer cares to contemplate the black alternative of unlimited propagation among the generality of the population who are not inclined to celibacy.

Medical Opinion in England and America

We come now to the study of a much larger group of professional persons—the physicians.

The medical leaders give almost the same warning as the social scientists with which to qualify their endorsement of birth control. It is not wrong everywhere and always, say both, but at present dysgenic and consequently in need of extension to the poor. But some of the medical men give their own turn to this rich-versus-poor argument by maintaining that many of the sophisticated class are ruining their women's health and morals and ultimate happiness by injurious types of contraception and by the self-indulgent small- or no-family system. Medical writers are sometimes so bitter that one suspects successful physicians of being surfeited with the complaints of wealthy and middle-class neurotics who might be quite healthy if they were occupied with the bearing and up-bringing of half a dozen children.

In preparing the following survey of opinion, I examined among others the *American Journal of Obstetrics and Gynecology* and its predecessor, the *American Journal of Obstetrics and Diseases of Women and Children,* from 1917 to 1926; volumes 40–43 inclusive of *Surgery, Gynecology and Obstetrics;* the *Pennsylvania Medical Journal* for the first two decades of this century, fifty-nine medical ar-

ticles listed in Julia E. Johnsen's book; and three extensive British publications, one the issue of *The Practitioner* for July 1923, which was devoted entirely to contraception and the others being from the Royal Society of Medicine papers, carrying a great deal on the subject, for May 1921 (14:2) and March 1922 (15: 3, pp. 38–48). Detailed references to most of these American and British articles will be found at the end of the Bibliography.

Altogether I collected from these and other sources one hundred and nine opinions. The American names were nearly all taken merely from articles and debates recorded in the periodicals, and so include only half a dozen of the twenty-five physicians actively interested in birth control clinics in this country.[17] The British names include some very famous ones connected with birth control societies, as well as those of physicians who have committed themselves in literature.

Favorable to birth control, either without any qualifications, or else for some adequate reason, are twenty-nine British physicians. Among them are such men as Sir James Barr, who spoke for birth control when president of the British Medical Association; Sir Humphrey Rolleston, K.C.B., Regius Professor of Medicine at Cambridge and Physician to the King; Lord Dawson of Penn, Physician to the King; Col. R. J. Blackham; Hon. Sir James Cockburn; E. B. Turner; Thomas Watts Eden, author of the leading textbook of gynecology; J. S. Fairbairn, of

[17] The Council of the Pennsylvania Birth Control Federation includes among the distinguished names which appear on its letterhead: George de Schweinitz, Alfred Stengel, B. C. Hirst, B. M. Anspach, N. W. Vaux and the late Lawrence Litchfield.

St. Thomas'; and Sir Arbuthnot Lane, the conspicuous surgeon.

Of the Americans whose favorable opinions appear in print there were forty-eight with such names as that of William A. Welch, one of the original Big Four of Johns Hopkins; Adolf Meyer (M-22) and Donald Hooker, of Johns Hopkins; the late H. C. Brainerd, one time President of the California State Medical Society; two presidents of the American Medical Association, who spoke for birth control in their addresses, Abraham Jacobi and William Allen Pusey (P-17); Cabot of Michigan (B-22); and Alice Hamilton, of Harvard. A few of these forty-five had not one, but a dozen articles in print. Four well known Canadian officers of health favor birth control. (B-14)

Then there are twelve American men who favor prevention only where abortion would be the alternative or under other stringent conditions.[18]

The frank opponents are twenty out of the total one hundred and nine. At least four of these are Catholics, although the American leader, Howard Kelly, formerly professor of gynecology at Johns Hopkins, is a Protestant. John McGlinn of Philadelphia, W. A. N. Dorland of Chicago (D-19), Rupert Blue and Hubert Work are other outstanding names among opponents. (M-17)

Editorials. I endeavored at the same time to survey medical editorials on birth control from 1920 to 1927. *The Medical Journal and Record* had one opposed, though

[18] In the Ohio Medical Journal, vol. XXI, 1925, p. 245–250, is a summary of eight other rather hesitating opinions of important men quoted by Tate.

its policy has since become favorable, *The Journal of the American Medical Association* has two in favor, and many notes and reviews showing no opposition. *The Medical Review of Reviews*, the *Medical World*, the *Medical Times*, the *Medical Pickwick*, *Medicine and Surgery*, and *The Lancet*, each have at least one favorable editorial; also four favorable articles by non-medical writers have been admitted by the editors.

Since this review was made in 1927 several notable recruits have appeared, lending active support to birth control, both in clinical and literary directions; for example, the Philadelphia physicians, G. Victor Janvier, Stuart Mudd, and A. Lovett Dewees; J. Whitridge Williams of Johns Hopkins; a Massachusetts group including among other distinguished names those of Drs. Gilbert Smith, Martin Edwards, Abraham Myerson, and John H. Taylor. The Committee on Maternal Health, of the Cincinnati Academy of Medicine, has a notable set of men and women including Charles L. Bonifield, Arthur C. Bachmeyer, Elizabeth Campbell, Robert L. Crudgington, Carl C. Wilzbach, Daniel J. Davies, Charles E. Kiely, William Mithoefer, Dudley Palmer, and Henry L. Woodward.

Votes and Symposiums. The following American medical *votes* and *symposiums* on the question of birth control will be found to grow more and more affirmative to contraception as the date advances.

The Committee reporting to the New York County Medical Society in 1917 (M-16) on a change in the state law gave an adverse majority report signed by C. E. Nammack, H. C. Taylor, W. H. Bishop, M. C. O'Brien, Frank

Van Fleet, and George W. Kosmak,[19] and a favorable minority report by two members of the committee, who were afterward supported in full meeting by three others. Three spoke merely against changing the New York law, and the meeting voted to adopt the majority report by 210 to 72.

In 1919 the symposium by the Medical Review of Reviews (B-27) received 47 replies, of which 12 were noncommittal, 28 favorable, 7 thought "nature's way the best, unhindered by man's guidance."

The New York Academy of Medicine, through its Public Health Committee (now the Committee on Public Health Relations) in its 1920 report suggested "such change in the existing law as would make the existing inhibitions inapplicable to duly licensed physicians, to licensed dispensaries and to the public health authorities in connection with the discharge of their respective duties in protecting the health of their patients or of the community."

Again, in 1921 speaking of state legislation, the Committee expressed itself in favor "of amending the law so as to confirm by legislative action the opinion expressed by Justice Kelby of the New York State Supreme Court, that the existing law permits physicians to furnish contraceptive information to patients when such information is essential for the preservation of the patient's health."

[19] Now an executive member of the Committee on Maternal Health. This change was foreshadowed at this meeting when he said he did not think "any physician denied the justice of birth control in certain instances." In 1930 he became chairman of a sub-committee on birth control of the Public Health Relations Committee, N. Y. Academy of Medicine.

In 1929, the Academy protested formally against the capture by the police of 150 record cards in the raid on the Sanger Clinic. In 1930, the Committee appointed a sub-committee to report on birth control, with Dr. Kosmak as chairman, and Drs. Ransom Hooker, Foster Kennedy and Wilbur Ward as members.

To the questionnaires submitted in 1924 to the members of the New York Obstetrical Society (A-5), the fifty-seven replies received contained only seven uncompromising opponents, whose names were not published. On the basis of this, Dr. Robert L. Dickinson, who was one of the members, considered his plans for research in birth control approved by this Society. He then secured the sanction of the New York Academy of Medicine and the American Gynecological Society (D-14), and the latter appointed a committee to coöperate with the group organized under the name of the Committee on Maternal Health.

In 1925, the Section on Obstetrics, Gynecology and Abdominal Surgery of the American Medical Association passed a resolution recommending changes in the law wherever necessary to allow control of conception by the physician. About this time the Kings County Medical Society of Brooklyn voted down birth control. The Chicago Gynecological Society had already endorsed birth control a year or so before. (D-4)

In 1929 the Medical Society of the State of New York appointed a Committee on Birth Control and Sterilization with John Osborn Polak, chairman.

Perhaps the best index to medical opinion in America was brought out by the questionnaire of the *Medical*

Journal and Record. The questions were so framed as to reveal the attitude of the physician on giving contraceptive advice for therapeutic, eugenic, euthenic, and economic reasons. Other points were covered, but these are sufficient for our purposes. About 317 answers were published in successive issues of the *Medical Journal and Record*, beginning January 4, 1928. Of this number only 16, or five per cent, were opposed to contraception on any ground, 122, or 40 per cent, favored it for some reasons, but not for all, while 179, or 55 per cent, favored it for *all* the reasons mentioned.

Dr. Ira S. Wile in 1929 made a special canvass of the faculties of leading medical schools in New York State. Altogether 421 professors in seven schools replied, of whom only 44 failed to regard birth control as an important medical question and did not think a change in the law necessary.

On December 5, 1929 a meeting of the Chicago Woman's Aid was presented with a "credo" signed by a group of eighteen leading city physicians, which set forth the "wisdom and justice of making legally available to any woman of legally marriagable age, the knowledge of how to prevent conception," under the heads of legal, medical, sociological and ethical considerations, and winding up with this:

"Finally, we as men believe that if we had to undergo sickness, disfigurement, limitation of activities, discomfort, pain, danger and sometimes death for the birth of a child, we would insist that it was our absolute right to choose our own time for the process. Therefore, we believe this an essential and absolute right of women and encourage them to claim such right."[20]

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[20] The following Chicago physicians signed this statement (B. C. Rev. Jan. 1930):

In Great Britain, Dr. C. Killick Millard's questionnaire issued in 1922 to sixty-five physicians showed rather more than half favoring the extension of birth control to cover purely economic reasons, which was a great sign of enlightenment at that date. (M-24)

About this time, the Section on Obstetrics and Gynecology, of the Royal Society of Medicine (P-14) listened to warnings by Herbert Spencer and Arthur Giles against quinine contraceptives as being a possible cause of sterility and by Louise McIlroy and Giles against sex excitement for women without maternity, as tending to cause fibroids, congestions, and neuroses. Amand Routh said lower birth-rate is unnecessary, as the Empire requires men, and Gibbons opposed contraception, but desired sterilization of the unfit. Only Thomas Eden's voice and that of Arthur Giles were raised to uphold contraception. So the next year a counter statement was published. *The Practitioner*, for July 1923, has twelve articles, most of which are by leaders in the profession, and which constitute an important contribution to the subject. In these articles, one of the two physicians recanted his former opposition to birth control, the Catholic representative registered his opposition with an astonishing statement, physiologically incorrect, while a majority of the other

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Charles S. Bacon
J. Wendell Clark
John Favill
Ralph C. Hamill
N. Sproat Heaney
Davis S. Levy
Selim W. McArthur
William Allen Pusey
Eugene S. Talbot
George H. Coleman
N. S. Davis
Anton J. Carlson
Eugene Cary
George W. Hall
George de Tarnowsky
Rudolph W. Holmes
Harold E. Jones
Joseph L. Baer

writers took for granted the necessity for contraceptives and settled down to the serious work of combating their dangers and uncertainties.[21] The maternity clinics in the government health stations have hitherto cared only for pregnant and nursing mothers, and have steadfastly refused to add birth control to their services. Now, however, it is expected that general gynecological clinics will be opened in the public health stations, which will be equipped to render contraceptive care.[22]

Early in 1927, a book called "Medical Views on Birth Control" (M-18) was published under the auspices of the Medical Committee asked to report before a lay organization, the National Council of Public Morals, in connection with the investigations of the Birth-rate Commission. This book purported to represent the findings of the Medical Committee, but actually only expressed the views of a minority group of opponents, as was disclosed when the formal proceedings of the Committee were published nearly a year later, under the title "Medical Aspects of Contraception." (M-15) This volume contained besides the transcriptions of the evidence presented by medical witnesses, who analysed the facts of their experiences, recommendations signed by a dozen physicians, in the main favorable to birth control.

[21] This quick crystallization of sentiment is characteristic of a compact country where they have "King's physicians," small, powerful coteries, like Margot Asquith's "Souls," influential duchesses and a couple of leading universities to guide their thoughts. See Hobson's recent book (H-5) for uncomplimentary remarks on the regimentation of English social scientists, which he describes as "graver than in America." In the United States we have not, whether for weal or woe, anybody to crystallize our sentiments.

[22] Personal communication from member of Birth Control Investigation Committee (Feb. 1930) (B-26).

Scientific Groups

Until within the past seven years medical opinion on birth control, like that of the general public, has been based on individual preferences and prejudices, and scant experience.

In 1923 the Committee on Maternal Health, envisioned and nurtured by Mrs. Minturn Pinchot, was organized to study contraception and related problems of human fertility, from the point of view of the practice of medicine and of the public health. (C-5.) In 1930 the Committee was incorporated under the name, "National Committee on Maternal Health." Its Executive Committee has fifteen members with the affiliations and special committee concerns indicated, as follows:

Samuel W. Lambert, M.D. (President of the New York Academy of Medicine 1927–1928, former Dean of the College of Physicians and Surgeons, Columbia University), *Chairman.*

Robert Latou Dickinson, M.D., F.A.C.S. (Senior Obstetrician-Gynecologist, Brooklyn Hospital; ex-President American Gynecological Society), *Secretary; Chairman* of the *Medical Advisory Group.*

Mrs. Gertrude Minturn Pinchot, *Treasurer.*

Mr. Bailey B. Burritt (General Director, Assn. for Improving the Condition of the Poor, New York City), *Community Relations.*

Elizabeth Campbell, M.D. (Chairman, Committee on Maternal Health, Academy of Medicine of Cincinnati, Ohio).

Katharine Bement Davis, Ph.D. (Former Director of the Bureau of Social Hygiene, author of pioneer studies of average sex life of American women).

Haven Emerson, M.D. (Professor of Public Health Administration Columbia University).

Robert Tilden Frank, M.D., F.A.C.S., (Chief Gynecological Service, Mt. Sinai Hospital), *Research.*

Barton Cooke Hirst, M.D., F.A.C.S., (Gynecologist to several hospitals, Emeritus Professor of Obstetrics, University of Pennsylvania).

Frederick Clark Holden, M.D., F.A.C.S. (Professor and Director of Gynecology, Bellevue), *Clinical Service.*

Ransom S. Hooker, M.D., F.A.C.S. (Late Professor Clinical Surgery, Columbia University College of Physicians and Surgeons; Director Study of Maternal Mortality, New York Academy of Medicine), *Indications.*

Foster Kennedy, M.D., (Professor of Neurology at Cornell University Medical College).

George W. Kosmak, M.D., F.A.C.S. (Editor of American Journal of Obstetrics and Gynecology and President of the Medical Society of the County of New York), *Publications.*

Samuel R. Meaker, M.D., F.A.C.S. (Boston University Commission on Sterility), *Sterility.*

William F. Snow, M.D. (Director, American Social Hygiene Association, Chairman of Experts on Traffic in Women and Children, League of Nations).

Marguerite A. Wales, R.N. (Director of Nurses, Henry Street Settlement), *Nursing Group.*

Louise Stevens Bryant, Ph.D., (degree in Medical Sciences, University of Pennsylvania, 1914; formerly Secretary of Publications and Research, Committee on Dispensary Development), *Executive Secretary.*

A general medical group of about sixty from whom executive members are chosen, includes representatives of the following medical institutions: Columbia University, Cornell, Bellevue, California, Michigan, Wisconsin, Pennsylvania, Boston, Chicago and Johns Hopkins Medical Schools, the Cincinnati Academy of Medicine, and more than twenty leading hospitals of the country.

The subjects studied by the committee include besides the control of conception, sterilization both therapeutic and eugenic, the causes, prevention and cure of sterility, the anatomy and physiology of reproduction and the actual sex life of socially normal persons.

Its methods include clinical and laboratory researches carried on in coöperation with leading universities and

hospitals, the study of results, and the literature; and the formulation of the factual findings for publication, both current in the form of articles and addresses, and in extensive correspondence and conference, and permanently, in book form. Some eleven volumes are under way, including: a technical handbook for physicians on contraception; a series of books on the actual average sex life drawn from thousands of medical case histories followed up over years, and analysed and grouped into several volumes, one, "A Thousand Marriages," another on the sex life of "Six Hundred Unmarried Women," a third which will be a source book of the case histories on which these are based, and a "Topographical Atlas of Human Reproduction;" two manuals on "Premarital Examination and Conjugal Adjustment" are under way, one for physicians, one for laymen; and finally volumes on "Sterility" and "Sterilization."

To date the laboratory researches have covered: ovarian function and ovulation, effect of lead on fertility, spermatoxin, physiology and cytology of spermatozoa, bacterial study of the normal vagina, and spermaticides.

International Group. After the Geneva Conference on Population in 1927 (P-16) the "International Medical Committee on Contraception" was formed, to act as an informal clearing house on methods and policies developed in twenty-odd countries under the general leadership of Dr. C. P. Blacker of London.

British Group. In 1928, the Birth Control Investigation Committee was formed in England with regular headquarters, and a formal organization to study the scientific and especially the medical aspects of birth con-

trol and related topics. It will publish the occasional reports of the International Medical Committee. This Committee is the only one besides the Committee on Maternal Health which undertakes to subsidize pieces of research, circulate questionnaires and to collect and study data from the birth control clinics. The two groups are in constant correspondence on their mutual programs.

The Birth Control Investigation Committee members are as follows:

Prof. Sir Humphrey Rolleston, Bart., K.C.B., F.R.S. (Regius Professor of Medicine at Cambridge; the King's physician), *Chairman.*
C. P. Blacker, M.B. (Guy's Hospital), *Medical Secretary.*
Mrs. Margaret Spring-Rice, *Hon. Treasurer.*
C. J. Bond, C.M.G. (One time Medical Officer of Health, Leister).
J. F. Huntington, *Hon. Treasurer.*
The Hon. Mrs. Marjorie Farrer, *Hon. Secretary.*
Prof. A. M. Carr-Saunders (Social Sciences, Liverpool University).
F. A. E. Crew, M.D., D.Sc., etc. (Director, Animal Breeding Research Department, Edinburgh University).
Mrs. Gladys Cox, M.B., B.S.
Prof. Winifred Cullis, D.Sc. (Professor of Physiology, London School of Medicine for Women).
Prof. Arthur Ellis, M.D. (Director of the Teaching Unit of the London Hospital).
Prof. Julian Huxley (Biologist and publicist).
F. H. A. Marshall, D.Sc., F.R.S. (Director of the Biological Laboratories at Cambridge).

SUMMARY

The legal status of birth control so far as clinic development is concerned is either favorable or neutral in most countries. Exceptions are Hindu, Roman and Greek Orthodox countries, France, and certain of our states, notably Connecticut and Pennsylvania. The United

States Federal laws interfere directly with clinics only by making supplies expensive and scarce and hampering the interchange of information, but their influence on men's minds is effectively inhibitory.

The practice of limiting population is immutably fixed in the customs of the people everywhere, the chief means being postponement of marriage, abortion, and contraception.

Except among Roman Catholics and imperialists, opinion is generally favorable to the practice of contraception by married people for adequate reasons. Endorsement is practically unanimous among social scientists, while among medical leaders strong backing has been secured. Medical opinion can now be formed on a factual basis, as the studies of various scientific bodies become available.

CHAPTER VIII

EFFECT ON THE QUANTITY OF THE POPULATION

A NECESSARY subject for speculation is the effect of birth control on quantity of population. The size of the future population must always be a matter of great practical importance as regards immigration laws and the long-term expansion programs of public utilities and other political and financial matters. Further, certain benefits have been claimed as likely to flow from birth control, such as fewer wars, higher wages, less unemployment, and lower land rents. The validity of these claims depends on whether birth control will really prevent population increase.

It will be well to examine the actual figures in the light of what can possibly happen. Let us suppose a maximum effect, at least upon families of over four, from an imaginary installation of eleven clinics in every city (the number which Los Angeles County now possesses). Let us suppose families larger than of four children are abolished. Now, in 1925 the total white births were 1,602,001 in the United States Registration Area (See Table VIII, Appendix B). The abolition of all births after the fourth would have reduced the white babies born by 372,607. If now the present white population is not to decrease (or if its present rate of increase, if any, is not to decline), upon such an installation of birth control there must be a compensatory

increase in first, second, third, and fourth white births to the number of 372,607 annually. Is this possible? Is it likely?

MAINTAINING POPULATION BY FAMILIES OF FOUR OR LESS

It would appear to be at least possible to maintain the present number of births out of first, second, third and fourth children alone.

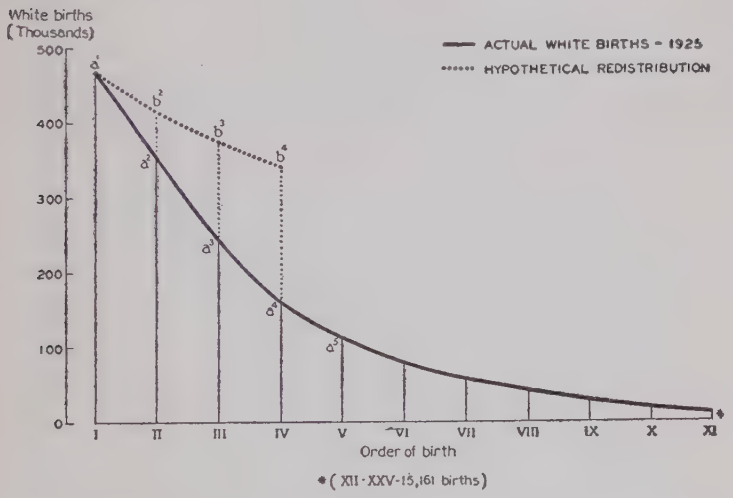

FIG. 3. POSSIBLE MAINTENANCE OF PRESENT POPULATION WITHOUT LARGE FAMILIES

See Appendix B, Table VIII. Based on U. S. Census (U-2)

In Fig. 3 the distribution of the actual births in 1925 is plotted, altitude a^1 representing the number of first births, a^2 the number of second births, etc. If now a maximum effect from birth control upon children over the fourth is imagined, the whole long tail a^5 a^6 a^7–a^{11} would

be abolished, but to compensate for this it is sufficient to raise the points a^2, a^3, and a^4 to the altitudes b^2, b^3, and b^4. For the sum of the distances a^2b^2, a^3b^3 and a^4b^4 equals 372, 607, the number of births lost by cutting off the long tail to the right of a^4.

It is a crucial point to be observed that the curve a^1, b^2, b^3, b^4 is no higher than the distribution curve which would probably be necessary to express the orders of births of this recent year if these women had been of our 1790 fertility—that is, of a fertility about twice as great as the present, as calculated by Alfred J. Lotka in his study of the size of American families in the eighteenth century. (L-5) Of course, we cannot know how that curve was shaped in 1790, but if one makes it start out with any sharper descent than $a^1b^2b^3b^4$, one has difficulty in getting in a distribution cuve all the 3,200,000 births (twice 1,602,001) which should have occurred if our bearing of women had been of a Colonial fertility. See Appendix B.

No recourse is had in this supposition to the further possibility of raising the whole line $a^1b^2b^3b^4$. If birth control shall increase marriage and decrease venereal sterility, especially one-child sterility, there might easily be a rise of five per cent or more in the altitudes a^1, b^2, b^3b^4.

It is thus physiologically possible for families of under five to maintain the present population without any births of a higher order to aid them. Furthermore, economic theory intimates that, society being relieved of the families of more than four, an equal increase can take place in the smaller families without reducing their standard of living. We are here following the old lines of argument urged by good authorities concerning immigration to the United States: if it had been forbidden during the last century, the home-grown population would still have made up the deficit and our population today would be no less.

IS SUCH COMPENSATION PROBABLE?

Is such complete compensation from small families to be expected? Will not the small families probably prefer

to raise their standards somewhat instead of raising their birth rates all of the whole compensating distance? The recent history of birth decline leads to this expectation. But on the contrary, an examination of the native white birth-rate in our leading industrial states seems precisely to show just such a maintenance (with transfer) of fertility.

MAINTENANCE OF FERTILITY WITH TRANSFER

By comparing the native white births of the year 1926 with those of 1923 (a year, it is hoped, sufficiently removed from the effect of war-postponed marriages), a nice increase of one or two per cent a year appears in native white births in Illinois, New York and New Jersey; and in Pennsylvania and Oregon, one third of one per cent (U-2, Tables numbered 7 in each report). But this arises entirely from a large increase of births in the fourth or earlier orders, only partly nullified by an absolute decrease in births of fifth to twenty-fifth orders. In California and Michigan, states to which our young native parents are probably migrating in considerable numbers, an increase of two per cent annually occurs, arising mostly out of the earlier orders. Altogether, there are nine states where the native white births increased and in only one (Connecticut) was the increase of later children kept even at par with that of the earlier. (The strange Mississippi figures must be due to increased reporting: an increase during three years of 20 per cent in total native white births, nearly that in the first four orders and 15 per cent in the remaining orders.)

On the other hand, because there are 17 other states (out

of the 26 states for which the figures are available beginning in 1923) where the native white births are absolutely declining, the total of these births is practically stationary. The changes between 1923 and 1926 for the whole registration area are:

	per cent
Decrease in births of *all* orders	0.1
Increase in births of *first four* orders	1.0
Decrease in births of *advanced* orders	4.0

This does not lead us to conclude that it is upon the births of advanced orders that we must depend for national increase. For, taking the detailed figures state by state, it is seen that, as we have said, absolute increase is found where the large families are losing ground, actually as well as relatively to the small.

But, in five states (Minnesota, Montana, New Hampshire, Vermont, Washington) where the large families are holding their own, still the state as a whole has decreased its births. Then in five other states (Maryland, North Carolina, Utah, Virginia and Wisconsin) with enormous decrease in orders of births over the fourth, of from 8 to 16 per cent, there have been: in three states, absolute increases of the early orders with the result that each state as a whole lost only 2 or 3 per cent; in Maryland and Virginia, merely a relatively greater decrease of the advanced than of the earlier births.

The remaining seven states declined about alike in the earlier and advanced orders, that is, there was no transfer of fertility.

The general tendency may be summarized as follows:

(1) *Increase* of net births is seen where, as in eight

states: there is a large increase of birth control to prevent children beyond the fourth, with transfer of a compensating fertility to the early orders. Exception: it is also seen in Connecticut with no transfer.

(2) *Decrease* of net births is seen where, as in seven states, transfer of fertility fails to occur; or where as in five states the large families are as numerous as ever (reversed transfer). Exceptions: it is also seen in five cases (Maryland, etc. above) where birth control is increasing faster in the advanced than in the earlier orders.

Thus except in six cases, increase of population is correlated positively with extension of birth control, unless indeed, all the phenomena are the result of migrations.

The explanation may be that net increase of births arrives with progress and prosperity; birth control for the hitherto large family also arrives with progress and prosperity; hence, they appear together.

It would appear that, thanks to prosperity in the biggest block of states, nine in all, including some large industrial states, native white fertility has been almost maintained, in spite of birth control against large families, by transfer to births under the fifth. The transfer amounted to 9,387 births in the three years in the 26 states.

This transfer may, however, be only apparent. The compensation from births of the earlier orders may arise in whole or in part from an increased proportion of younger women in the population and not merely from the increased income saved to society because it no longer has to support as many children of the advanced orders. But this if true only postpones the test. It may yet be found that when the influence of "age-constitution" has

run itself out, compensation (increase of the earlier births) will still continue as fast as the advanced orders of birth decline.

The increase or decrease of native white births *at least appears* to be a very sensitive index as to how prosperous and satisfied the majority of solid citizens are feeling in any given state. The nine states with net increasing births, named above, gave, as I understand, sixteen senatorial votes to confirm Chief Justice Hughes and two against him, these two being from California and Michigan where the birth-rate, being partly due to migration, is less significantly favorable in my opinion than in the other seven. The seventeen states where we know the native white births are falling showed their dissatisfaction with the powers-that-be by voting against Mr. Hughes almost as much as for him, with only three extra votes, according to my hasty investigation, in his favor.

Thus one can not assert that birth control clinics will have any effect on net population, or at least any new effect. (But, as to quality of population, obviously there may be some effect.)

The major fact is that the birth rate has been declining for very many decades without stopping the continual increase of European white stock. This stock is still outstripping the orientals by strides, though not by leaps and bounds as before (R-8) (T-5) (E-1), a fact which "Yellow Peril" propagandists choose to ignore. All our practical affairs are geared now to the expectation that this will continue but at a declining rate, such as has governed since the turn of the century.

In the balance of the chapter we will take up testimony

and evidence as to the connection between contraception and this birth decline which has not precluded net increase of the stock.

EFFECT OF THE NEW YORK CLINIC

It is mathematically possible to calculate that if every one of the 4,500 clinic patients in New York during 1928 would otherwise have had a child, their failure to do so would have actually tripled the decline in the increase-rate that was already taking place in New York City, as shown by the vital statistics.

But all such calculations are vain, for the reasons that it cannot be computed how many of the patients would have prevented pregnancy or birth by other means even if the clinics had not existed, nor can it be discovered to how many neighbors each patient passes on the information she has. Moreover, the very publication of the news that a birth control clinic exists, is a signal drawing all persons' thoughts to the desirability and possibility of limiting their families—to which end they then direct their own ingenuity without applying to the clinic. It is probably in this manner that the greatest effect is brought to bear on the birth-rate though its extent is not calculable.

Indeed, the effect may possibly be negligible because the populace may already have decided (of course unconsciously) on how many children they intend to have. Altered habits in America seem already since Revolutionary times to have cut the rate from eight to four per mother. (L-5) Are we not perfectly able to cut it to three or two at any time and without the intervention of clinics? Clinics may merely be an improved means of so doing.

CONTRACEPTION A MEANS OR A CAUSE?

In deciding the question whether the birth control propaganda of the last half century has been, and the clinics of the coming period will be, a *true cause* of declining birth-rate or merely a *means* to reduce a rate bound to decline anyway, a few analogies may clarify the issue.

In cities where most suicides are by gas, is gas the cause of suicide? The answer depends on the rate of suicides in cities without gas. Similarly we will inquire in this chapter into what the decline of birth-rate has been in groups without contraception.

When one dashes by motor to nurse a dying son, the car is not the cause but the means of one's going. When one takes the car two miles for a dish of ice-cream the car is in part the cause. In the first instance to remove the car would not stop the going; in the second case it would. Similarly, in viewing the birth-rate one must consider the strength of the motives involved; also the number of factors involved. If there are a considerable number of old, well-known ways, beginning with that of Onan (Genesis 38: 9), of limiting the family or of reaching a dying son, the probability grows that modern contraception or an automobile are means rather than causes.

EVALUATING THE VARIOUS CAUSES OF A GIVEN BIRTH-RATE

The effect of contraception on the birth-rate, whether great or small, is at least relative to other influences. Their comparative strength is a riddle that may well last out our time. Nearly two centuries ago Montesquieu

said: "In the human species, the manner of thinking, the character, the passions, the humour, the caprice, the idea of preserving beauty, the pain of childbearing, and the fatigue of a too numerous family obstruct propagation a thousand different ways." (M-27) Today it is the aspiration of population science some time to evaluate the relative importance of these "thousand" ways, and of other factors too, such as hygiene and wealth.

THE CAUSE OF THE RECENT DECLINE

Most contemporary scientists consider few things more certain than that contraception has been the *means* of the recent great decline in the birth-rate, but as to whether it has also been the true chief cause of the decline or whether the main causes have been other, a sharp controversy has raged for two decades. There is a very large school of eclectic thought which rests simply in the belief that, as we have said, the causes are always many. There are various other groups, each small, which fasten their interest on some one cause and give it all the weight. To me these groups have, as it were, forgotten to look for suicides other than by gas. Sometimes these men give actual evidence of the narrowness of their view, failing, though they look at other countries than their own, to look at other ages, or else vice versa, or failing to look at the death-rate as well as the birth-rate.

It is doubtful whether this debate would have arisen if the sociological evidence summarized in Chapter VII had been in court (Compare Vogel, Ref. V-2). If all the scholars had fully realized that societies everywhere use voluntary means to restrain 25 per cent to 50 per cent of

their fertility in every generation, they would have perceived that quantity of population has always been delicately responsive to control. For a 25 per cent suppression in a single generation quickly becomes, by compounding, 99 per cent of voluntary results after a few generations have passed.

PARTISANS OF OTHER SINGLE PRIME CAUSES

There are those like Gini (G-2), conscious of Italian inferiority to ancient Rome, and like Brownlee (B-34), with his mind fixed on the great irruptions of vitality in Old England and among the Norsemen in certain ages, succeeded presumably by later decline, who view the present birth decline as merely part and parcel of a general decline of vitality, either temporary or permanent. A general decline, however, may conceivably be itself composed of many factors. In such event, Gini and Brownlee would be eclectics too in their view of the ultimate causation of the birth decline.

Then it is possible to view either hygiene or the fall of the death-rate as a prime cause. Hygiene having reduced the death-rate and having also "promoted . . . a sense of responsibility," the birth-rate goes down. This is Methorst's view (M-21) and Bouthoul's (B-33).—But are not here already at least two factors, hygiene working through two things as diverse as physiology and psychology? (D-20) And certain acute critics of hygiene having pointed out that the incidence of tuberculosis, for instance, falls about as fast in countries without "T. B. campaigns" as in countries blessed with them, would add that there is also an economic factor, or at least, some

factor additional, involved also in causing the death-rate, and in response, the birth-rate, to decline.

Then there are those, largely represented all through the nineteenth century, who seem to have rather hard-and-fast views either that birth decline is chiefly caused by economic adversity, or, on the contrary, by its exact opposite—economic prosperity.[1] The socialists are pretty well committed to the prosperity theory, as it is the only theory that guarantees that their communistic policies will not result in undue over-population. But the great Kautsky and also Talquist, the Frenchman, are honorable exceptions to this unthinking dependence on a single factor; Kautsky admits that in about a century after the adoption of socialism the population problem would have to be seriously studied in all its obscure causations. (E-7) Thus we must add these two socialists to our abundant list of eclectics in the next section but one.

THOSE THINKING CONTRACEPTION A TRUE CHIEF CAUSE

Professor Gruber of Munich (G-4), politically a conservative, is one who sees no cause for the birth decline except contraception catering to ingrained human laziness and egotism. (See also Ref. T-3, p. 144 ff.)

Sir William Beveridge, although he admits man has always controlled his birth-rate and that all this pious adjuring him not to meddle with it is a mere passing fad, like "laissez-faire" in economics (B-6), yet insists that prosperity was mounting fast in 1880 and the great birth decline since that one particular time is inexplicable ex-

[1] See Refs. E-7 and R-3 for excellent histories. These two groups have in the past consisted of more numerous scholars than now.

cept as caused by increased knowledge of contraception. (S-16) He proceeds to intimate that the continued practice of birth control is probably unjustified today.

The preëminent medical statisticians, Sir Arthur Newsholme and Dr. T. H. C. Stevenson, and especially the latter, also regard contraception as both means and cause of the decline. However, Sir Arthur in his recent revision of his "Elements of Vital Statistics," gives the views of the opposite parties (N-7, pp. 106-8), and only a single phrase about "the generally adopted view" which was once, if it is not still, his own (N-6), and which regarded contraception as a prime cause.

Does Sir Arthur face the crux of the question even as far as Beveridge does?—That is, does he cease considering birth-rate as a thing apart and begin considering it as an integral part of population increase? Being no economist by profession, he has excused himself from inquiring concerning the populations which were growing so fast in spite of birth decline; if there had been no decline, *what would the numbers have amounted to*, and would men have tolerated the increase, or would they in the absence of contraception have turned to increased celibacy or to war far sooner? If they would not have tolerated, contraception or no contraception, a greater population increase than the actual enormous increase which is a matter of history—far greater than any recorded in the world before (Y-4)—then the birth decline, and contraception, are the means they took to a purpose that moved them. The cause in the whole matter would be the purpose, and behind that, the necessity, which moved them to keep population within bounds tolerable to them. If they

had no better means, they might have returned to whatever customs sufficed to lower the birth-rate of decadent Rome.

But let us name other believers in contraception as being the main cause. Miss Elderton (E-4) is perhaps one. Four members of the Royal Statistical Society readily assented when in 1906 Stevenson and Newsholme took their stand on contraception being the main cause. (N-8) But in the twenty years of papers and "Discussions" on population since then I did not find a single one assenting; except that Dudfield, in denying that increased physical infertility has caused the decline, clothes cautiously his evident leaning toward Stevenson's position in these words only, "One always thinks of New-Malthusianism." (D-23) Did everyone else during twenty years think it went without saying that contraception is the cause, or did they feel (unconsciously) that it is a means rather than a cause?

As stated earlier, Dublin is almost the only American social scientist to take up the cudgels against birth control, and we had known of no American at all taking the exact Beveridge-Stevenson position. But a recent "special article" in *The Times* (D-26), of a very questionable tenor,[2] mentions a report soon to appear by Dr. Kuczyn-

[2] We trust that Dr. Kuczynski is misquoted in the statement attributed to him (D-26) to the effect that *if* the present fertility and mortality rates continue "the population of France, and especially England and Germany, is doomed to die out." Races are necessarily either increasing, stationary or decreasing. If one takes any race at a moment of decrease and premises that the pendulum will never swing back, then many races can periodically be pronounced "doomed." But the false premise is buttressed in the article under discussion by its intima-

ski of the Institute of Economics, Washington, D. C., with introduction by H. G. Moulton, and states that "it is understood that the conviction of these specialists is in accord with that of Sir William Beveridge," though the report itself "makes no attempt to determine the cause of the birth decline."

Finally, should one place the great Berlin authority Prof. Julius Wolf in this short list? In his recent pronouncement (W-6), which brings up to date his famous "Der Geburtenrückgang" of 1912 (W-7), he places the progress of contraceptive knowledge apparently on a par with his "change in the sexual morals" or "rationalization of sex-life in our time." This latter all along has been his main emphasis and is about what is generally meant by neo-malthusian *propaganda* as distinct from the teaching of actual methods. So far, he seems firmly with Beveridge, Stevenson, and Newsholme. But Wolf says this very change in the sexual morals is the *result* of a

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tion that Dr. Kuczynski sees the birth-rates running level for many decades before 1875 "in a normal way" and since then declining in a firm, determined manner as if they meant to keep on declining. Not a word is said about children's death-rates during this earlier period when births were "normal" nor a word about total increase. Were *they* running level? Were *they* normal? No indeed. The white race was increasing (R-8) at a rate to run all the other races—including the rabbits—off the face of the globe if we in our turn premise that this pendulum too would never swing back. On the contrary, an all-'round view of the abnormal; i.e., *not* normal, situation before 1875 would have indicated that something was *bound* to happen. The thing that has happened to relieve the situation has been the decline of the birth-rate. *The Eugenics Review* for July 1929 notes on page 130 that Dr. Kuczynski's deductions about the next generation's birth-rate neglected to consider the possibility of many more women marrying.

general breaking with tradition, of a new style of living, of a rising self-consciousness, of a progressing emancipation of the masses, and especially the women. Would Wolf admit, then, that births would have declined anyhow, and nearly as much, without special birth control devices and propaganda? That is the crucial question. If Wolf would answer "Yes," then he is not properly to be placed in this section, for he would regard contraception as a means which the real cause (general progress) has merely seized upon as its instrument. And it should also be noted that Wolf admits six other causal factors: declining mortality of babes and young children; rising age at marriage; male decimation by the war; pauperism; urbanization; rising pretensions. But these are all, he says, distinctly secondary in importance to his "changing sexual morals." (J-6)

THE ECLECTICS WHO RECOGNIZE MANY FACTORS IN THE DECLINE

We come now to the most numerous group among the learned writers on population. In the course of collecting about one hundred articles dealing with population growth—I found: (a) *thirty-eight definitely eclectic* on the cause of the recent decline; (b) very many whose opinion I could not determine on this single narrow issue; (c) a number of single men and small groups of men devoted to various single explanations. Most of these small groups have already been described, for instance the seven mentioned in addition to Wolf as believers in birth control as the cause. Writers in German, Dutch and English were represented, besides half a dozen opinions also from

France and Italy. Among these writers, let us now take up the thirty-eight eclectics one at a time.

GERMAN ECLECTICS

When Julius Wolf was mentioned in a preceding section rather than being placed here among the eclectics, it was finally and conclusively because of the point on which he has based his fifteen years of disagreement with the two other leading German writers on the subject. These two men, Brentano with his famous Wohlstand theory, and Mombert (M-26), and four of their disciples, are typical eclectics. (B-31) (B-28) (D-27) (M-7) They say time and scientific progress have brought many changes; notably, increased education and prosperity, and *in consequence* of these changes the birth-rate has fallen. Wolf has said the sequence was just the reverse: the birth-rate fell because (even *he* has to admit a cause!) of anti-religious, anti-traditional popular education and unethical propaganda in favor of birth control from the rich downward, and only afterwards there resulted an increased individual materialistic prosperity.[3] But whether or not this commits Wolf to a very narrow base as the root of the great birth decline, these six other Germans and also Theilhaber (T-3) are convinced it is broad-based on many environmental factors, physical as well as psychological.

The circularization of Saxon physicians[4] by the Saxon

[3] This interpretation is taken in part from a book by Wingen (W-5), one of a series edited by Brentano and Lotz; in part from the Handwörterbuch der Staatswissenschaften; in part from Wolf. (W-6).

[4] Herr Referente Kluge, Artzliches Vereinsblatt, 1912, No. 896, Ref. from T-3, p. 40.

Government in 1912 elicited the opinion that Neo-Malthusianism played scarcely any rôle in the enormous Saxon birth-decline, which "rests on a willed lessening of the number of children, *long customary from ancient times among peasants*, for many years among other circles," (italics ours), which lessening is attributed to psychological and economic conditions.

DUTCH AND FRENCH ECLECTICS

The division was as follows in the 1922 meeting of the Dutch Economics Society, which has 711 members. Study was wholly devoted to the population question (B-7): Brunner, Wiltens, Van Zantin showed themselves eclectic as did also Ries who led the debate for the liberal thinkers, and also Stuart, Wibaut, and Kuyper, but these last four put particular emphasis on the economic factor although they acknowledged many other factors too. Five other speakers seemed to think economic adversity was the all-controlling factor nearly to the exclusion of every other, including contraception. The man who led the debate for the conservatives and Catholics was supported by about two other speakers and two were noncommittal. In fine, there were seven eclectic speakers; there were five prejudiced in favor of the economic factor alone; and there were a couple of smaller groups among some of whom may have lurked the opinion that the birth decline is entirely due to the "wicked invention" of contraception. Methorst, the dean of Dutch statisticians, and no eclectic, does not appear in the debate, but he said to me personally that contraception, which he thinks immoral, had had no influence whatever on the birth-rate

even in Holland, which is considered the home of birth control. His view of causation has already been given.

In France, we have Dumont. (D-24) True, he repudiates in Chapter V the following explanations for the declining birth-rate: wealth, poverty, vice, intensive agriculture, lack of emigration, wars present or past, or the military service required of laborers. He says it is rather to be explained by French characteristics: "centralisée, catholique et idéaliste." But his famous theory of social capillarity would seem to place him among the true eclectics, for it views the possible parent who is deciding whether or not to have a child as reacting to his own ideas about whether there is any chance to rise in the world if he refrains from parenthood, which ideas are to some extent founded on actual political and economic conditions. And social matters also come among Dumont's factors for he explains India's high birth-rate by blaming the caste system for preventing *social capillarity;* i.e., the tendency of people to try to rise by restricting their birth-rate or by other efforts. Thus, Dumont is at least eclectic enough to recognize factors from fields as diverse as psychology, politics, economics, and sociology.

The great French statistician, Lucien March, is most plainly an eclectic. (M-5, p. 256)

Those many Frenchmen who, like Risler (R-5), are promoting a successful raising of the birth-rate in French industries which give bonuses to married employees are naturally no longer believers in the prevalence of contraception as the sole determinant of the birth-rate. They must be eclectics or else believers in economics as the determinant.

ENGLISH ECLECTICS

English opinion as reflected in two decades of debate on population at the Royal Statistical Society has been moving in the eclectic direction, with Yule as spokesman. Perhaps the high water mark of the twenty years' discussion is touched in his address before the Society in 1925 (Y-4), especially if we include Professor Edgeworth's wise and cynical comments when Yule sat down.[5]

Yule had shown his grasp of the kernel of the matter nineteen years before, when he first entered the field against Newsholme and Stevenson (Y-3) (N-8), as follows:

Newsholme's concluding contribution to that early debate was, that it was very strange that countries of different economic conditions throughout the Western World should all decline in birth-rate together, if economic and general conditions were the cause of the birth decline rather than the single moral (or immoral) cause of contraception. Yule countered with this—why should countries of different moral condition all decline together? Thus early the riddle is stated: Is the decline consonant with individual (moral) changes or with economic and other environmental changes? To the modern student of economic cycles the evidence is clear that economic influences quickly become world-wide, with prices (and unem-

[5] Ref. (Y-4). Professor Edgeworth opined that even if Pearl's critics are right that entirely other mathematical curves fit the growth of population just as well as Pearl's logistic (which, as Pearl has noted, was "Verhulst's logistic" as early as 1845), that is nothing against Pearl and his logistic; and this tool of Pearl's may still be the most convenient and if there are other possible tools as well, so much the better! He further opined that "*future generations may look back upon our fears that the birth-rate is too high or too low much as we regarded the alarm caused in the past by the rise or fall of prices.*"

ployment?) rising or falling in all countries together. But moral influences show consonance much more slowly, requiring decades rather than years.

Nineteen years later Stevenson (S-16) and Yule (Y-4) return to the fray. Both have become more eclectic, particularly by the inclusion of mortality as a very important factor in the birth-rate, but Stevenson has not abandoned his position—he is still pointing, all astounded, to the *suddenness* of the *all-European* birth decline in 1896–1900, and he steps aside for a moment to take a fling at the logistic curve of population. This theory of Pearl's and of others is of course not agreeable to him, seeing that it or any long time curve taking into account both birth- and death-rates would explain the *suddenness* which so troubles him; namely, if there had not been a suddenness about birth there would have been, because of declining death, a far more astounding suddenness about total population. Even as it was, counters Yule, Germany, Austria, Italy, and the Netherlands showed a higher rate of natural increase than ever before in recorded history. (Y-4, p. 33)

Other high lights of this paper of Yule's are as follows: He claims that Swedish and Finnish statistics show the birth decline beginning in 1750. We may note that this is long before Malthus, but not perhaps before the influence of four great works cited by Stopes, one in Arabic and three in Latin, all in the sixteenth century according to Stopes—except Sanchez in 1623—and all dealing definitely with contraceptive devices. (S-23, p. 253–6) Stopes believes that protectives for men originated in the defensive efforts against the great outbreak of syphilis in the

sixteenth century. Thus research is pushing far back of 1896–1900, or even of 1875, the beginnings not only of the birth decline, but of contraceptive devices, and is showing that the latter arose out of general progress; for instance, out of medical progress in fighting a disease, which disease in turn may have been itself transferred to Europe because of the increased progress in transportation, trade, and geographic discovery. (See also Ref. S-23, Ch. 8) On the other hand, it is greatly to be doubted whether the influence of any Arabic and Latin works could have been large among the populace of distant Sweden and Finland. One would rather credit Sweden's early birth decline to an early progress in general culture which used as its immemorial tools celibacy, late marriage, abortion, and Onan's device. But whether culture was earlier disseminated among Scandinavian peoples than among others is, of course, a point to be determined. I am only aware that Denmark had about 1812 the earliest compulsory education law anywhere on earth, and that literacy and favorable mortality are generally superior in the Scandinavia of recent years.

Another high light of Yule's 1925 paper is its concluding query, which lays down what he judges as the population problem next in order to engage further scientific inquiry: Why is France's population stabilized at a number so far above subsistence level? He makes no answer. The easy reply is that nations or tribes scarcely ever increase population at the price of lowering standards of living once attained, and that France at present is not able to increase production and population without lowering standards. This easy answer does not take into account that

France encourages immigration. Why does she not recruit her stabilized number by slightly raising her own birth-rate? It may be that a great deal of progress will be made in population problems by regarding each prospective parent as a citizen of the world rather than of any nation, and more affected by socio-economic than by political divisions.

Other English eclectics are Major Darwin (D-3), Greenwood, President of the Royal Statistical Society, 1928 (S-17), possibly Elderton (E-4), Pell (P-4), Rathbone (R-1). Then, to my thinking, Baines is an eclectic, although in the discussion on his paper (B-2), Stevenson hails Baines as a partisan of his own views. Baines, formerly head of the English census office, mentions neo-Malthusianism in a rather, to my mind, subsidiary rôle: he is "not aware of statistical support for" the cyclical hypothesis; "nor do I think," he continues, "that physiologists now accept another theory current in the last generation—that a decline in producing power is consequent upon an increased demand upon nervous power. . . . The explanation is far simpler. A rise in the standard of comfort, and of education which leads to the appreciation of that rise, tends surely and directly towards the voluntary restriction of the family. . . . In this country the falling off of the birth-rate coincided with the relapse after the 'boom' in the early seventies. The resources of the family began to be straitened, and . . . compulsory schooling and factory legislation, etc., led people to look upon a full quiver as inimical to the standard of living they had once attained. The ground was well prepared . . . for . . . neo-Malthusianism. . . . Possibly too . . .

gainful occupation now open to women may have had . . . effect."

NEW-WORLD ECLECTICS

It should not surprise us to find new-world scientists more eclectic on this subject than any others. This is to be expected in a new-world society heavily endowed with natural wealth and never looking on things as about to go to the dogs either morally or economically. We know our American birth-decline has been heavy, but scarcely from poverty alone—nor has the new world any imperialistic reasons for raging at contraception and fastening on it as the solitary guilty agent of a "racial decline." The late Sir George H. Knibbs of Australia was an eclectic. (K-6)

Some American eclectics are Wolfe (W-8); Gillette (G-1); Rossiter (R-8, p. 569); Thompson (T-5, p. 576); Hotelling (H-8); McIver (M-14); Glover (P-16, p. 43); Bushee (B-39); Sweeney (S-29); Reuter (R-3, p. 171), who carefully divides all causes of birth decline into "a knowledge of the means" and a great number of other causes which he handles at length; Kelsey (K-2, p. 337), who gives fourteen causes "direct" and "indirect" among which he specifically mentions "exercise of self-control" as a possible cause. Then there is Pearl (P-2): of course, *all persons* committed to the idea that population grows in certain normal ways (by smooth curves) through the ages will see the smooth curves arrived at through the action of many forces tending to neutralize each other's temporary irregularities. Such students must recognize a number of forces—hence, must be eclectics.

FACTUAL EVIDENCE ON THE QUESTION AT ISSUE

Are there any nations or groups where contraception was absent while the other factors remained in force? If so, under this omission of the single factor which we are studying, what was the result? Thus might we estimate what weight to attach to contraception as a factor in quantity of population.

We are to look, then, for "modern" groups or nations in which modern contraception has been comparatively absent, and inquire what was the result as to quantity of population.

THE CASE OF IRELAND

Ireland is the most significant instance. No contraception but comparatively speaking no babies! There we have as much certainty that contraception has been absent as we are likely to get anywhere, for under the influence of their religion they have the highest birth-rate in Europe per married woman between the ages of fifteen and forty-five. There is one child every three and a half years, or 295 annually per thousand women. (S-13) We may observe, however, that this is considerably lower than the supposed physiological norm (L-5) (M-23), whether because of (a) late marriage, (b) continence in marriage, (c) contraception, (d) disease; or because the supposed norm is not a norm for the non-emigrating parts of the Celtic race. There is some evidence for the last supposition in that the Irish rate of childless marriages is high, but of marriage itself, low (T-6), and of illegitimacy (R-3, p. 139) very low[6]—hence, it might appear that the

[6] Ref. (T-6.) The emigrants appear to be much differentiated from the home-stayers; their birth-rate being lower and the illegitimacy

Celts who remain in Ireland have their own sex-norm, of possibly less sexuality. On the other hand, it may be supposed that (a) (b) (c) and (d) all have their age-long part, increasingly as the centuries pass, in causing the declension of the rate, in Ireland as elsewhere, below the supposed norm. This eclectic view is supported by the observation that the Catholic birth-rate (crude) in most other countries declines like the Protestant, but at later dates. (T-3) In Ireland itself, the high birth-rate to married women has declined in the last five censuses from 309 to 295 per thousand. (S-13)

Ireland is a very satisfactory instance to study also because it has more fully felt the industrial revolution than the other races to which we shall later advert: i.e., the Algerians, the Afro-Americans, the French Canadians. Thus, Ireland fulfills the conditions we desired: no contraception, comparatively speaking, but many other modern influences in full swing. What is the result to the Irish birth-rate (crude per capita, not per married women) and Irish growth of population?

The Irish birth-rate reacts to advancing civilization as does the rate of other western European nations, only more so. By a very great use of celibacy (B-1) and of emigration of persons in the reproductive years, she keeps her crude birth-rate at the moment the lowest in all Europe except Esthonia (M-21) and her population the only one that has actually declined in Europe—and that heavily—during the last eighty-six years. Thus a firm stand against contraception has helped the "Ould Coun-

being higher, for instance, in the United States for the Irish than for anyone except natives and negroes and Canadians. (U-1, p-16).

try's" march toward empire through sheer weight of numbers *not one step*. Nor has her stand against contraception injured Ireland in her struggle against poverty in so far as poverty depends on numbers. Indeed, inasmuch as France, for instance, choosing just the opposite—increased contraception, little emigration, and little celibacy—has had a slightly increasing population, the evidence is that contraception has been favorable to French imperalism and unfavorable to the decrease of poverty in France. Not that we would really make any such argument! Scraps of argument such as the above merely encourage one to say that the connection between contraception and quantity of population is obscure and, as likely as not, minor.

We have said that the Irish have used two methods to limit their increase in Ireland: (a) celibacy, (b) emigration. But these two methods are on a par only in the minds of those who are obsessed with interest in political boundaries rather than in biological racial realities. A real limitation of Irish increase, a real Irish defeat, is to be found in their celibacy; a much less real limitation, and perhaps an Irish victory, lurks in their habit of emigration provided that the emigrants on arrival in the New World manage to increase and not to decrease as they have done at home.

Indeed, one may say that the Irish opposition to contraception has forced them out of Ireland to enter upon their often-mentioned political conquest of the United States. A true estimate then of the effect of anti-contraception on Irish progress in the world could be made only after one knew how far the defeat involved in their celibacy at home has been neutralized by their biological

career elsewhere. By 1910, the eight millions of Irish in 1841 had grown into less than four and a half million in Ireland (T-6); one and one third million Irish-born in the United States and about two and a half million of Irish parentage there (U-3); an unknown number of Irish-born and of Irish parentage elsewhere out of Ireland; an unknown number of persons of more distant Irish descent from the eight million of 1841, both here and elsewhere.

However, all this is beside the point that interests imperialists. Imperialists have only small hopes from a large population dispersed over the whole world. Is it not proved that keeping out of birth control was not sufficient to raise the quantity of Irishmen at home?

Seeing that the Irish substituted celibacy and emigration for contraception and so reduced population on Irish soil while all the rest of Europe was increasing its population, we must now enquire in what proportion these two means were utilized. This is very important to our inquiry as to whether contraception is a *sine qua non* of population reduction or merely a tool snatched up by nations which happen to prefer it to the regular good old kit of tools. For, emigration to an emptier land is scarcely one of the regular kit. It is so often not available. The question is, then, how far did celibacy alone avail the Irish?

The authorities are not agreed. Newsholme says (N-6, p. 21): "Its low crude birth-rate is entirely explained by the fact that emigration, especially to the United States, has left the motherland with a very small proportion of married women of childbearing ages." But in spite of the word "entirely" in this passage, Sir Arthur adds in the next sentence but one: "There is behind this

the fact, suggestive of adverse economic conditions, that in 1901 only 32.5 per cent of the women in Ireland aged 15–45 were wives, as compared with 46.8 per cent in England and Wales." And Sir Athelstane Baines, being at the time chief of the English census office, says: "Instead of these conditions (high fertility of married, stationary death-rate, and very low infant mortality) resulting in a high rate of natural increase, they were neutralized by the extraordinarily low marriage rate.—Even then, if emigration were to cease, unless the Irish people married more, their rate of increase would still take an unusually long time to fill up the country." (T-6)

One thing is sure about the Irish situation. It is time certain statisticians recovered from the blind spot in the eye with which they regard her infertility. The figures show her as infertile as France. But after the jugglery known as "standardizing" the birth-rate, her infertility doesn't look to these people like the infertility of France. This is unreasonable. French women marry but don't bear—comparatively speaking. Irish women don't marry and don't bear. What is the difference as regards the birth-rate? None. The only possible excuse for Irish infertility is the age constitution of her population. Statisticians should cease for these purposes to conjoin marriage rate with age-constitution in their explanations (standardizing) of birth-rates. Only the latter is an excuse for infertility, if even that. That is, they should "standardize" the birth-rate only for the age-constitution, if at all. One of the more recent contributors to the Royal Statistical Society, de Jastrzebski, expresses his doubts of age-standardization rates thus: "I am still of the opinion that it (the crude birth-rate) is in some respects the best,

and indeed the only measure of the actual reproductive forces of that population." (D-9)

THE CASE OF RUSSIA

The legalization of abortion and of contraception and a wide government circularization of birth control pamphlets has not interfered with an increase of *thirty-one* per cent in the rate of population growth—from 16 per thousand in 1913 to 21 per thousand in 1925 (L-7), or twice the United States rate, and the United States rate is one of the highest in the world. (M-21)

But it will be urged that vast Russia is not an instance of truly modern conditions. One may, then, consider Moscow and Leningrad alone. Professor Lubinsky shows that now when abortions are financially free to many, and unrebuked to all provided that the operations are done by state-designated medical men and are registered, the new registration brings the *revealed* rate of them at Leningrad in 1926 to nearly thrice what it was in 1924, but the birth-rate mounts too, from 1924 to 1926, till it is higher than the median birth-rate under the Tsar in 1911–1913. (L-7)

Thus in these cities where conditions are modern we see contraception free to all, abortion allowed to all, and yet a mounting birth-rate.

THE CASE OF THE FRENCH CANADIANS

Here we have the best evidence there is on the side of those thinking contraception a real prime cause. These Catholic Canadians do not practice birth control and their numbers are rapidly increasing. It remains only to ask:

are their conditions in general truly "modern?" The suspicious facts that they have not agreed on one official tongue for their nation, that they still weave and make soap at home (M-1) and bake out of doors, and that there is still a good bit of "free land" and pioneer economic opportunity for their surplus offspring on the Canadian frontier, all suggest that presently we may see a change. When the "last frontier" is closed, will they not follow the path of the European French or else of the Irish?—In either case, their birth-rate will fall.

THE CASE OF THE ALGERIANS

Raymond Pearl has offered the Mohammedan Algerians as an instance of a group whose birth-rate has declined without the aid of contraception faster than that of the French colonists among them, though both are declining much more slowly than the French rate in France proper. (P-2, p. 116)

THE CASE OF THE AFRO-AMERICANS

The American negro may be supposed not to practice contraception largely. Some devices are expensive and intricate, others are expensive and distasteful to self-indulgent men. Although Monroe N. Work, the authority of Tuskegee, believes the negroes know as much as the general public about birth control, he does not say whether they practice it as much.

What now is the birth-rate of the American negro in the presumable absence of modern contraception and in the presence of other modern influences especially in the northern states?

It is easy to reply that the negro birth-rate has been the same as the native white in Washington, below in Utah and slightly above in New York, North Carolina, Oregon, Pennsylvania and Virginia. In most of the other twenty-one registration states and the District of Columbia, it has been somewhat higher; being usually below, though sometimes slightly above the birth-rate among foreign-born mothers. (U-1 p. 13) A more recent census volume (U-2), which gives a comparison of colored merely with all whites (native and foreign-born conjoined) shows a lower colored birth-rate in Florida, Kentucky, West Virginia, and Mississippi (probably due to defective registration) and a far lower rate in seven northern states where negroes are not numerous.

Do these similar birth-rates seen in groups both using and not using contraception prove that it has no influence? No, the critic of the eclectic theory will reply, disease, particularly venereal, is the cause of the low negro rate through sterilizing some negro parents and causing abortion and still-birth in others—a very particular condition; so that this negro case is no argument for the view that many eclectic factors always control birth-rate and population.

But let us get into the matter a little further. A study of the authorities[7] and the fountainhead of information, the United States Census, shows a striking situation from 1820 to 1910. Reuter says: "In the nineteenth century the native negro stock increased 663.3 per cent, while the native white stock increased 693.3 per cent." The figure for the negro is exact, but for the white it is an estimate.

[7] Willcox (W-3), Reuter (R-2) (R-3, p. 246), Thompson (T-5, p. 582), the census (N-3).

In both races there has been a decreasing birth-rate, a decreasing mortality "by approximately the same amount" in both races (Willcox) and a slackening rate of increase—in fact, a parallel all along the line.

We have here a picture that arrests the eye. Is it a true likeness as to birth, death and increase, of two widely divergent groups of people responding similarly to the usual eclectic factors: chiefly, an increasing population pressure affecting both groups and a common stock of increasing knowledge abroad in the land? Or is it a truly like reaction only in the matter of the death-rate and is the declining birth-rate a result of disease in one case, and of conscious effort in the other?

Much as I would like to rule out venereal disease for the sake of the negroes' good name and for the sake of simplifying the argument, it cannot be done. I am too much impressed with the steadiness with which the negro rate of increase (N-3) remained close to 23 per cent per decade from 1830 to 1880 (if one levels out the fall usual during a great war and the subsequent rise which is not uncommon). Since 1880, that is, since the days of the last negro married couples brought up under the old stabilized conditions "before the war," the rate of increase has been declining with astonishing rapidity till it was only 6.5 per cent in 1910–20. (R-2) Dr. Walter M. Brunet, an expert on the subject of negro disease, gives his belief that the situation in the southern states has changed tremendously during exactly this past half-century as regards venereal disease among negroes, and he says with the greatest emphasis that it is *impossible* to rule this out as a probable cause of their great birth decline. The

Negro Yearbook for 1925–6, published at Tuskegee, admits that syphilis has been increasing rapidly in the last decades.

However, be the cause what it may, this declining negro birth-rate exists, and probably not as a result of contraceptive methods.

A harsh, unthinking view of negro and white men in this country is this:

The white birth-rate is low.

The negro birth-rate is high, or would be if it were not for that happy (?) accident that venereal disease keeps it down.

Therefore, a low white birth-rate is to be feared because only this happy (?) accident of negro venereal disease, which might at any time abate, prevents a terrific negro increase.

But the enlightened view I believe to be as follows, *whether or not* it is venereal disease that is destroying potential or actual negro infants:

The white birth-rate is low.

The negro birth-rate is low and *will remain so to match the white race.* For the venereal diseases and other afflictions lowering negro fertility are no accident, but are in the expected nature of things. These misfortunes are the normal result of the coexistence of two unequal cultures and racial stocks struggling for space in a limited area. They are the signs of an at least temporary negro defeat in the struggle for existence. A white race which has had to cut down its own offspring far below the number prevalent in Colonial times has no specially tempting jobs to offer to colored people. According to the present belief of many historians, slavery was doomed, and even with-

out war would have vanished through economic reasons as it did in Porto Rico. Thus negroes have not been wanted even as slaves, and as free working men, they take the place of white men's sons who could, and presumably would, have been bred for the purpose if there had been less population pressure upon area. The white racial-consciousness of all this results in a very hostile environment for the negro. The young negro man is unsettled in his mind as to his future occupation, location and the amount of peonage he intends to put up with, and he has an unsettled grasp on property, on vocation, or marriage *mores*. Hence, he and the negro girl as well fall into irregular sexuality. But if venereal disease were wiped out tomorrow, all these fundamental factors would continue to operate, although through other, and probably less effective means.

Venereal disease is of course one cause of slow negro increase, but it is a cause originating in other more profound social and economic difficulties of the negro. Is venereal disease destroying those strong black races which are giving the Dutch and English such competition in South African agriculture? I believe that the Afro-Americans' rate of increase declines for the same complex of fundamental reasons which causes the white rate to fall, among which are chiefly a filling geographic area and a rising standard of living and of aspiration by both blacks and whites. The crowding and the rising hopes make the whites increasingly jealous of any encroachment on their jobs, privileges, and property, at the same time that the negro's own rising hopes make him feel more restless and more desperate. In consequence he lives more irregularly, consorts with low whites whom in a more normal *milieu*

he might have no use for, and contracts venereal diseases and vices of all kinds.

IMMEDIATE ANTECEDENTS VERSUS MORE FUNDAMENTAL CAUSES

The means of the negro birth decline may have been in part the increasing use of age-old devices such as more desertion of too-fertile wives; more abortion, possibly; later and less regularized marriage; more use of age-old contraceptive devices like Onan's. Certainly venereal disease has increased.

The real causes of this decline lie deeper. They are, as always, to be sought in the interplay of area, population pressure, the progress of the arts and the ideas of the age, in addition to the increase, especially with urbanization, of venereal disease. It is no accident, and probably nothing unusual, that these four fundamental influences affect visibly the psychology of the dominant portion of the community, and strike rather secondarily, *but still infallibly*, on the more submerged. The whites say frankly: life is too hard to raise a large family, and modern improvements too tempting The negro lives out the same reaction with far more despair as he wanders dejectedly from one job, and one mate, to another, tempted on by easy rail and automobile transportation. This is well shown in "Rainbow Round my Shoulder." (O-2)

THE CASE OF MINERS

We may note now some facts of a reverse order, but with a similar bearing on the connection between contraception and the birth-rate.

Miners in a number of countries have been found to have a higher birth-rate than almost any other class.[8] Various explanations have been offered. McIver thinks their fertility "a phenomenon of their group life." (M-14, p. 295) Compact group life favors normal sexuality and family life, just as the individualism of a large-city life injures the same. Some people think that the employment of the women, prevalent in textile but rare in mining communities, is the determining factor. One man thinks that contraceptive knowledge is not so easily passed over the back fence between one miner's cottage and the next, as it is over the loom between one textile operator and the next, the textile worker's birth-rate being very low.

Only the last of these explanations gives any grounds for thinking contraceptive ideas and devices are less accessible to miners than to the unskilled laborers, for instance. Yet, the mining birth-rate is much higher. Why?

Thus it appears that there is probably another factor than contraception more determinative than it is—be it compactness of community life, non-employment of women, or what-not. Our own preference for an explanation would be: the psychological temperament which leads a man (or rather, a family stock) to adopt this peculiar, dangerous and subterranean trade, also leads him to reject contraception as a means and family limitation as a purpose. Miners, unlike the Irish, marry much and early; hence, we say that they reject the purpose as well as the means of contraception. Also it is advisedly that we said that his temperament "leads a *man*" to adopt the miner's

[8] Ref. F-2 for British. A significant analysis for America appears in Ref. O–5.

trade and miner's family policy of comparative non-limitation. There is some evidence to show that the adoption of contraception is more dependent upon the man's attitude than upon the woman's.[9]

The "Fertility of Marriage" (F-2) gives some evidence corroborative of my view (p. cxvii) tending to show that miners reject contraception right in the midst of a community that accepts it. It is shown that they maintain their high birth-rate in a county where an equal number of mostly working people are maintaining the usual low birth-rate common to England and Wales in general.

Therefore, we say miners form a true example such as we sought; though in reverse of the other groups we have been observing which lack contraception and yet have a low birth-rate. Miners on the contrary have contraception available, as freely as laborers anywhere, and yet have a higher birth-rate than anyone else.

COLLEGE WOMEN

Evidence concerning the birth-rate of American college women, carefully reviewed by Huntington and Whitney (H-10), shows their unparalleled low birth-rate as prob-

[9] Such evidence is to be found in Stopes' statistics of the type of contraception most in use in England (S-24, p. 42), and also in the great volume of the English Census "Fertility of Marriage" (F-2, p. CLII, CLIII), where it is shown that the Irish immigrant woman's marriage to an Englishman results in a fertility more restricted—that is, more in accordance with the English husband's ideas—than does a marriage of an Irishman to an English woman, where the Irish husband's ideas of unrestricted fertility can be presumed to have more weight. And exactly likewise among Russian-English mixed marriages and among marriages of mates from different English localities.

ably due *not* mainly to contraception, though birth control was no doubt more available to them, when and if they wanted it, than to almost any other class in America. These authors say, p. 49: "Those who have children still have enough to replace themselves." *But* "childless married people, together with the great number of the unmarried, are mainly responsible for the decline in the college type." And college women are "no more likely to be sterile than are women of other classes of society who are married *at the same age*" (italics ours). That is, college women have a very, very low birth-rate not from contraception but from non-marriage or late marriage—two immemorial means of keeping down the birth-rate.[10] The authors observe that, according to those best qualified to judge, complete childlessness is scarcely ever voluntary, but they suggest it may be due to the use of contraceptives in the first years of a late marriage. For it is probable that very inadequate fertility is commonly latent in a woman who marries at thirty years of age. I object that this does not exactly show contraception as being to blame for college women having fewer children than the general population, for they have just as many as the part of the general population which also marries late—that is, they are no more injured, if at all, by contraception. College women have fewer children than their compatriots because they marry less and later. Neither of these causes is exactly contraception.

[10] See Chapter IX on the use of such means as these in Poictiers for some centuries before the French Revolution.

ITALY

Another straw showing which way the wind blows in these matters is seen in the current news from Italy. Mussolini inveighs against birth control and institutes taxes on bachelors, etc., but what good does it do him? Not only did the births fall off by about 15,000 in 1928 (according to the New York Times, December 2, 1928), but the marriages fell off *nearly twice as much*. In Italy non-marriage is an immemorial resource against over-population, and celibacy is a sacred state.

SUMMARY

It is possible to keep up the present United States birth-rate without any family having more than four children. In nine states, there are straws pointing in this direction. However, what is likely, is a population in the United States *increasing at a lessening rate of increase*, just as it has been doing for a very long time; and with the birth-rate falling fast as regards births over four but pretty well compensated by increased births of the earlier orders.

The reasons for expecting that the net growth of population will be thus essentially unaltered by further birth control are as follows:

Men of every time and clime have voluntarily regulated their annual crop of offspring by various elastic devices. Perhaps partly on this premise, thirty-eight population scientists regard the great birth decline of the last half-century merely as an inevitable response to the falling death rate, the standard of living, the progress of the arts and many other factors. But we found eight to ten men who held that birth control was the prime cause of

this birth decline. Four of these scientists held prominent official positions under the British and German empires at a time when those empires ardently desired more citizens. So loudly did they castigate birth control from their dominating positions that in 1916 we find Professor Willcox, dean of American writers on population, able to say, "there is not a single one among the experts who denies contraception as the great underlying cause of the modern decline in the birth-rate of all civilized countries." (W-3) But by 1925 the scientific pendulum has swung the other way in response to the dread revelation of unemployment and other signs of population pressure following the War, and Professor Willcox gives this crystal-clear summary of the scientific change:

> "There are two quite different causes suggested as the main cause [of birth decline]. One is the growth of population as a biologically self-regulating phenomenon closely connected with the density of population; and the other, a volitional control of the phenomenon effected by the spread of the birth control movement. It is wise for us to hold our judgment in reserve until more facts accumulate." (W-2).

In an effort thus to accumulate facts, we have examined all modern cases we could find. Of course in most groups contraception appears entangled with other "modern conditions" so that it is impossible to be certain what caused the birth decline, but at times it was disentangled. Thus the Irish showed a minimum of contraception and a maximum of birth decline; the Afro-Americans probably had, of all Americans, a minimum of contraception and they showed an exactly average decline; the Algerians had no contraception, or less contraception than their French officials and colonists, and their birth-rate declined faster. The Russians have a rapidly rising birth-rate in the

midst of a tremendous official campaign in favor of contraception and legalization of abortion. The Italians have a rapidly falling birth rate caused even more, it seems, by increasing celibacy than by increasing birth control. In the same way American college women maintain a minimum birth rate solely by marrying late rather than by using contraception more than the average American. Miners maintain a maximum rate though there is no evidence to show that contraception is kept from them more than from other workmen. Of all these seven cases about half tend to show no connection and about half show a negative connection between amount of birth decline and amount of contraception. We found one case of positive connection, namely, the French-Canadians, although the suspicion remains that the lack of decline is not due to lack of birth control but to lack of all modern conditions.

Is it not best to regard the birth-rate as a summary index of almost everything important that is going on among a group of humans,—continually reflecting all important changes?

QUERY CONCERNING THE ORIENTALS

What is the bearing of these views on the problem of the swarming orientals? Is it in vain that great things have been hoped for in the East from the extension of birth control?

What shall one tell our discouraged medical missionaries and famine experts? One physician asks for dried milk for the Chinese babies in her district whose parents now give them a tea made from manure (a substitute for

the leaf vitamines of milk?). When I ask her if infanticide and abortion are common she says, "in my district infanticide is tremendously common but not abortion." In other districts abortion is abundant. (M-12) (M-2) (S-23, p. 251) When I ask her if birth control would not be better than these evils in China (C-2) and in Japan in the old days (O-4) she admits it. Shall one go on and tell her that according to the majority of theorists, the Chinese are already controlling their population as much as they care to in view of their universal desire to provide for descendants to carry on their ancestor-worship, and that if they substituted birth control for all their abortion and infanticide, still their famines and low standards would remain?

Such would, I believe, be the outcome if birth control could conceivably be instituted alone, without other modern developments. But actually, it cannot and will not come alone.

As China feels the impact of Western ideas, ancestor-worship will no longer remain the chief main-spring of Chinese life; the selfish desire of each to see himself personally immortalized will yield to more cosmopolitan and more patriotic feelings. Thoughtful Chinese will weary of being scornfully associated by all the world with their countrymen's low standards of living. Let the Chinese get a broader ideal than the familial and personal; a hearty wish to see China honored and magnificent and no longer disordered by famines and by homeless brigands following countless "generals" to war. Then, clinics or no clinics, infanticide or no infanticide, population will be restricted.

There is more help in the Idea,—in the proud words "birth control"—than in a hundred clinics. Margaret Sanger will be long remembered as the inventor of that phrase. (S-4, -5, -6, -7)

And there is help in many other ideas which focus thought on the necessity of limitation. Such ideas were powerful enough to keep the population of Japan practically stationary for one hundred and twenty-five years of peace prior to 1840 (O-4) and many other societies have also willed to have a stationary population.

But at the present moment in Europe, ideas on population seem less clear. Europeans grasp the population situation of the Orient, but in their own case some of them persistently close their eyes, as human nature is wont to do, to the complete, bitter truth. I refer to the question of why American standards of wealth and comfort are higher than theirs. They are interested in this. They publish a flood of books ascribing our wealth to types of production or rates of wages, and so on—books in which the basic fact is ignored. This is, that if less than half of their population could be turned loose in Europe which had somehow been emptied of all the other Europeans, then the area and the resources *per capita* would be somewhat nearer to America's. The fortunate remainder of the population could then set to work to make themselves as comfortable as their blood brothers have done in America.

CHAPTER IX

EFFECT ON THE QUALITY OF THE POPULATION

An attack has been launched, as stated in Chapter IV, against the clinic movement on the score of racial quality. The attackers may or may not admit that the movement is humanitarian and promises to relieve suffering and remove fear. Probably for the most part they dislike it and call out "dysgenic!" in an attempt to kill a movement of which they disapprove. However that may be, the argument must be met squarely.

The argument is that, whether or not the movement does immediate good, it will do ultimate harm because it will decrease the proportion of superiors in the population and the population will deteriorate biologically. Eugenic circles in England are not much worried about a dysgenic effect from their clinics (D-2), but such doubts are still voiced here. In the Eugenical News[1] of April 1928 is a book review of editorial tone and placing which says, "the fear haunts many that the contraceptive teachings will be practised principally by the well endowed, so that the percentage of well endowed children will fall in subsequent generations. Until that fear can be relieved, some eugenicists will hesitate before entering enthusiastically upon anticonceptional propaganda." This voices a general

[1] At the time, official organ in the United States of the principal eugenic societies, published in Cold Spring Harbor, Long Island, N. Y.

objection to propaganda directed to any class—for the "well-endowed" may be in any class.

In meeting this argument, let the attack be given the benefit of every doubt. The case to be met is as follows. All or most qualities, good or bad, are up to a point inherited. If those persons with good qualities leave proportionately less children than those with bad qualities, the population must deteriorate. (C-6) The clinic movement tends to increase the existing disproportion between the birth-rates of the different classes, or (according to others) to decrease the children of the cautious, "well-endowed" man in every class, while those of wild, "ill-endowed" men still flourish in their former numbers. Therefore, the clinics are deleterious.

Let us examine the case in four stages. Let us first ask whether the proportion of the well-endowed can be diminished by a differential birth-rate. It will be seen that the answer is not as obvious as it appears at first sight. But giving the benefit of any doubt, let us go on and see, in the second place, whether the present differential birth-rate which has started most of the hue and cry, is a true measure of the rate of contribution to the next generation. Doubts again emerge. Once more putting them aside, let us see whether the present differential birth-rate is really unfavorable in the biological sense. It will be found that this has not been proved. But supposing that it has been proved, let us finally see whether clinics are increasing or diminishing the difference between the birth-rate of the classes and between that of cautious men and of careless men. Unless they are increasing it, the whole case falls to the ground.

CAN THE SUPERIOR BE DIMINISHED BY THE DIFFERENTIAL BIRTH-RATE?

It seems obvious that, if qualities are inherited, then if those possessing a good quality, let us call it A, leave fewer offspring than others, the population will deteriorate. But biologists advise us that this does not really follow. At least it does not follow that any change which takes place will have a serious or rapid result. And this is not because they deny the truth of inheritance. It is because they take into account facts of inheritance which others forget. If good quality A is inherited as a single factor, then obviously, if those who have it leave no children, good quality A will be lost. But if quality A is inherited as the result of 100 factors, then those persons with 99 or less are almost as likely to have children with these 100 factors, as those who have 100 themselves. That those who exhibit the quality leave no children will make little difference because others have also most of the factors required for the exhibition of the quality and when they marry their children may get the missing factors from the other parent. The importance of this lies in the fact that most human characters are the product of many factors and therefore it seems that a differential birth-rate can cause less change than is generally supposed.

J. B. S. Haldane has studied the problem mathematically in great detail over a number of years. (P-16, p. 196) He finds that low fertility does seriously affect traits inherited as simple factors. "But," he says, "intellectual traits are not . . . inherited in that simple manner." We may add that certainly emotional and probably physical traits of importance are also not inherited in any simple

fashion. "With a complicated trait carried by, say, only one per cent of the population, a fifty per cent defect of fertility by this one per cent will not entail a fifty per cent reduction in the presence of this character in the next generation, but only a reduction of much less than ten per cent." This does not mean that the superiors cannot be decreased by a differential birth-rate but only that a very large difference in fertility produces but a small result. Most of those who have got hold of the notion of inheritance forget, or more likely are not aware of, the complications of inheritance, and exaggerate the possibilities of change for the better or for the worse through a differential birth-rate.

But this is not all. Haldane supposed that those exhibiting the desirable character did in fact possess a factor which determined it. But this may not always be the case. It does not always follow that if you breed from a section of the population to your liking you will get a population such as you desire.

Suppose you desire hens with a high laying capacity. You select as parents hens with this capacity and expect to raise a population of hens with high egg production records. This has been tried. "For more than ten years," says Pearl (P-3), "only the highest layers were used as breeders. But a superior race was not produced. On the contrary, the average production of the flocks steadily declined during the period. Taking the same stock at the end of the trial, however, and intelligently using the progeny test [i.e., as to eggs of progeny] as the basis of perpetuation of breeding lines, it was possible to raise the level of flock production to a high position and hold it there."

Why was this? It was not because high laying capacity is not inherited. It was because the high layers did not all inherit the capacity, but exhibited it for other reasons. The same is probably true of most human characteristics. They are inherited but may also be exhibited by those who have no unusual inherent factors, and conversely, a capacity may be present and inherited, which is not exhibited. Therefore, rough and ready selection of the good performers may have little result, and selection by differential birth-rate is rough and ready.

So the matter passes a stage beyond Haldane's results. He showed that exact selection produces in complicated cases only slow results, and others have shown that most of the selection which takes place is not exact and produces few or no results at all.

It seems likely therefore that the selection that has occurred among men, whether through the differential birth-rate or by other means, has had very little result within historic times. No doubt much selection has taken place. Certainly the differential birth-rate is no new phenomenon. The "upper classes" in various societies have again and again had notably few children. Pages of literature in each civilization are filled with comments that the "upper classes" have no children and are dying out. According to Gini, the birth-rate among crowned heads has not been high. (P-16, p. 166) Consider mediaeval Europe. In every generation huge numbers of men and women of the upper classes entered monasteries and nunneries and dedicated themselves to celibacy. Professor de Lapouge has followed the history of the traders of Poictiers for two or three centuries. (D-10) Disease

took a heavy toll in each generation. Possibly he exaggerates the deaths through disease because, if a name never appears after baptism in connection with marriage, wills or death, he assumes early death, whereas exactly the people to have emigrated were those for whom marriages and bequests were hard to manage. Apart from this, however, of the survivors, de Lapouge found "only two, three, rarely more" who had married and founded a family. The rest became priests or nuns or remained unmarried to help at home. Not merely one or two children, but no children at all, was the deliberate choice of large numbers of each generation of the well-to-do classes in mediaeval Europe.

A differential birth-rate was active in mediaeval Europe, and appears to have operated against the upper classes. It may always have been active among the upper classes in each phase of human history. But what do we find? If the differential birth-rate led to deterioration, we should expect evidence of continual decline. We do not find evidence pointing to this. On the contrary, students of anthropology and others are coming to the conclusion that, for perhaps 10,000 years, there has been little change in European intellectual capacity. There is evidence of stability, but not of change for the better or for the worse.[2] This would be a puzzle if we had to believe that the differential birth-rate spelt inevitably decline. But the researches of Haldane and the breeding

[2] Why, one may ask, have the men of exceptional I.Q. in the days before birth control failed to outbreed all the others and raise the level? *Perhaps* they have; but if they have not, it may be because such men, even in the dawn of civilization, may have desired wives of an I.Q. low enough to rest their own minds and flatter their own egoism.

experiments of others (J-1) make it possible to understand how differential breeding may go on and yet be followed by no serious results. (D-1) (H-1)

DIFFERENTIAL BIRTH-RATE VERSUS REALIZED FERTILITY

For the sake of argument, however, let us give our opponents the point. We will assume that the differential birth-rate is bad, and that, if the superiors have two children on the average and the inferiors three on the average, it is, so far as it goes, deleterious. But it does not necessarily go very far. Suppose that the two children of the superiors survive and marry and that of the three children of the inferiors one dies and the other two only survive and marry, then we are all square again. In other words, any differential birth-rate may be completely altered by differential mortality and by four other factors about to be described.

This is a very important problem. There is a widespread tendency to jump to the conclusion that differential birth-rate implies a difference in realized fertility. By a difference in realized fertility we mean a difference in the average number of descendents who survive and marry in the country. If this rate of realized fertility is the same for all classes, and if the "turn-over" (the age at birth of children) is the same, then there can be no biological effect. Let us therefore consider the matter in some detail.

Of the accidents which can nullify a differential birth-rate, only one, infant mortality, has been at all closely considered by scientists. But a death which occurs between the age of one and the age at which marriage is

possible is equally important from our point of view. A third factor is no less important, and that is the marriage rate. From our point of view any one who survives to become an adult but does not marry might just as well have died. Another factor is emigration, which is of importance in Europe. It is possible that there may be more emigration from one class than from another (see Chapter III), and since we are considering the effects upon one country, anyone who emigrates might just as well have died. The counterpart of the emigrants in the United States is the hobo class. They usually do not marry, but neither are they counted among the single men if at census time they are domiciled in shacks and freight cars as they usually are. It is as if they had emigrated or died. Again, there is the "passing" of persons from one class to another.

Finally there is to be considered—and this item probably is the only one greatly increasing instead of decreasing the effect of high birth-rates in the lower classes—the earliness with which any class has its children. This is of great consequence, as shown by the following purposely extreme instance.

Suppose that of four artisans each dies at thirty after having had three children; suppose four upper class men die at sixty after having had four children born to them between the ages of thirty-five and forty-five: and that the children follow their fathers' examples. At the end of sixty years there will be more than thirty-six children of the artisan class and only sixteen of the upper class in spite of a higher (supposed) upper class birth-rate.[3] But

[3] The sixteen will very soon be having children of their own, but so will some of the thirty-six.

note concerning this usually important matter of the "turn-over" of the generations, that it does not function at all in any group where the realized fertility is unity; that is, where each pair averages two fertile offspring during life.

Altogether we get a very difficult statistical problem when trying to see which classes are increasing, with particular necessity to note that biologically (disregarding nurture) it does not matter how long a class lives on, after they have had their children, but only how many they have had, and at what age. Also one wonders how to handle the fact that some may regularly have their children in a lower class and eventually pass to a higher class after child-bearing is mostly done; and vice versa.

FALSE DEDUCTIONS FROM BIRTH-RATE

The English census volume on the Fertility of Marriage, published in 1923 (F-2), was for a while deemed to have brought us a long way on the road towards measuring the high birth-rate of their lower classes and showing that these rates really resulted in a high reproduction comparative to the upper classes. However, one now realizes that this great work of Dr. Stevenson's, and even Carr-Saunders' correction[4] of its figures to allow for marriage

[4] Prof. Carr-Saunders applied the differential marriage-rate, which is quite low among English laborers, to Dr. Stevenson's fertility-rates for marriages of completed fertility, and thereby narrowed the differential till it shows the following children surviving per male (P-16, p. 133):

Class I	2,437
Class II	2,895
Class III	3,251
Class IV	3,222
Class V	2,941

rate (P-16, p. 133), omit numerous factors necessary to a judgment. No allowance can be made for differential emigration, for "passing" from class to class and for the illegitimate who cannot be dismissed since they comprise two and a half times as many births as are numbered among the legitimate births to class I[5]. But the chief difficulty not met, or only partly met, in this line of inquiry is in the matters of differential mortality and of the "turn-over" of successive generations.

Thus, with this type of data, it is impossible to get much idea of the different class increases. The links which are most grievously missed are: the *age of parents* at birth of children (to give the turn-over) and the *death age of offspring* who died, whether before or after reproductive age. Dr. Stevenson, who wrote the great Fertility of Marriage Report, admits it himself. (S-15) He says "The lack of knowledge of the vital factor of age was a constant embarrassment and difficulty" to him. Dr. Stevenson also admits that this former type of English inquiry by which each household is asked to tell of the births and deaths of offspring during as much as fifty years (if the marriage has lasted so long) depends very much "on the memory of the public." It would put an absurd, intolerable burden on that memory if the items italicized above were added, as they must be if true differential increases are ever to be gotten. So he recommends the scrapping of this type of inquiry in favor of that from the birth certificates. By adding one query to them; i.e., "What is the father's age?" he says it will be

[5] See appendix A for a careful description of the content of these classes.

possible really to compute class increase provided the Life Table is worked up by social classes for the years of youth now missing from the "Life Table by Social Classes."

Class increase, yes; but not, he goes on to say, the historical changes in class increase, not at least for many decades. Hence in order to get a little light on the latter, Stevenson would like the inquiry to escape scrapping and be retained for just one more census. While it is very imperfect, it sheds, he thinks, some light on historical trends. In deciding this, weight will no doubt be given by the English authorities to another fundamental weakness of all in this type of inquiry, which is as follows:

The material is very seriously biased as regards the past; namely, only surviving married pairs appear; all their dead contemporaries are allowed to rest as if they had never been. Even the death of one parent before the census day cut the whole family out of the picture. The material may give such false results as these: if, as is possible, rich people living protected lives usually both live till the wife is forty-five, but if at least one of a pair of poor people often succumbs to diseases of poverty, to vice not medically mitigated, or to industrial accidents, before they have had the five or six children, or any of the children, they would normally have had, the apparent birth rate to the poor of past decades will be exaggerated. Thus many small or zero families occurring among the weaker pairs of the lower classes may not have got into the picture while there may have been few "weaker pairs" among the upper classes to get left out. A "weaker pair" is any pair where one is dead before the wife is forty-five.

It is bad for showing long trends. Because the surviv-

ing parents who married in 1861 have accumulated big families, we must not suppose that the far more numerous dead, and hence weaker, brides and grooms of that bygone year had any such families. Indeed, the bridal pairs of but two years ago have a birth-rate credited to their date of marriage and class higher than is proper. For there recently existed pairs of whom one or both are now dead already within the two years and they, if they had been known and counted, would have doubtless reduced the birth-rate for that date and class. E. C. Snow, a well known statistician, criticised this type of statistics when they were first published for Scotland in 1914. (S-13) He amused himself by applying these methods to the population of Ireland, and, by using the same biased method, proved (!) that the married birth-rate had *greatly* declined there, whereas every one is convinced it has declined only a little.

None of these remarks of course apply to the comparison of the actual observed number and size of families alive on the census day of 1911, with the actual observed similar data if it shall be taken on the census day of 1931. Many students of population will ardently desire that Dr. Stevenson should be allowed to include this observation in the 1931 census for comparison with 1911.

I was told in 1926 by Dr. Methorst, the head of the Dutch census and secretary of the International Statistical Bureau, that the English "Fertility of Marriage" type of inquiry published in 1923 was neither designed for, nor did it succeed in, throwing light on these eugenic questions.[6] And he showed how the Dutch were planning

[6] There also exist French and Australian differential statistics, referred to later in this chapter, but they, no more than the English, are adequate to throw light on eugenics.

to be the pioneers in getting this information by the use of a revision of their police card just then come from the printer.[7] The woman's card has a space for her husband's occupation and very many spaces for each of her confinements (to be marked "boy," "girl," "female stillbirth," etc.) *with the date thereof*, and of course the card carries her own birth date. Thus Holland will be prepared with what Stevenson declares is required: age of parent at birth of children.

In the United States some students (O-5) have worked from the histories on the birth certificates as summarized by the Census Bureau in Ref. U-2, and some from the census day schedules of 1910 (S-30). But in the first study as well as in the second and in several others (see studies listed in Ref. S-30) the Fertility of Marriage type of inquiry as to "children ever born" was followed. It is not easy in the United States to pursue the method recommended by Stevenson and Methorst; that is, to inquire how many births occurred annually to any class—day laborers, for instance—for the base numbers with which to make comparison are not well established, such as the total number of day laborers in the United States. We are further yet from such a complete enumeration of the great social classes as they have in England—namely, the "unskilled," "skilled," and "upper."

[7] Carried in Continental countries by every adult citizen throughout life to show to the police on demand. The police card has never been submitted to in Anglo-Saxon countries. But it would seem that in the United States where nearly every man and many women carry an automobile driver's license, it can presently be developed. The present license might be unified in form throughout the continent and made to appeal to pride by some title after the individual's name like "member of the Registered Stock." Then we would have a Registration Population as today we have Registration States.

Figures on "children ever born to mothers of forty-four" make allowance for some of the "passing" from class to class, but may be weighted unfortunately by the differential survival of "stronger" couples only.

Articles in the leading newspapers of England and America (F-4) declare that the new volume of the English census (O-1) shows the unskilled (Class V) increasing less rapidly than the upper class (Class I). The figures on which this conclusion is based are shown in the accompanying Table, "Occupational Mortality, Fertility," etc.

The commentators compared the rates of column 4 with ditto of column 11 showing about the same small excess of births over deaths in Class V as in Class I. Does this prove Classes I and V increasing at about the same rate? It seems in thus depending on these calculated rates the commentators neglected the warning of the authors in this very census volume (O-1) on p. XCVII:

> "But after all, the point of chief interest is not so much the variation in potential as in *realized* fertility, of the various occupations and classes. If we wish to compare their relative rates of increase (or decrease) by difference between births and deaths, age, within limits, and marital condition, are immaterial, and *all we require is the ratio of births to men of reproductive age, married or single.* From this point of view the effect is the same whether paternity is avoided by avoidance of marriage or by measures taken for the purpose after marriage. For this reason . . . the Annual Report for 1912 shows the ratios of birth both to all males and to married males under fifty-five years of age. . . . But this point of view (total class or occupational fertility, irrespective of marriage) has not been catered to in Table A."

I cannot, however, agree with this quotation any more than with the conclusions of the newspaper commentators. Yet more is required than what is mentioned in the words I have italicised above; namely, there is needed the age

OCCUPATIONAL MORTALITY, FERTILITY AND INFANT MORTALITY IN GREAT BRITAIN

From Registrar General's Decennial Supplement, England and Wales, 1921, Part II, Table A. Published in 1927 (a)

Occupation	Mortality of Males Aged 20-65 in Each Occupation 1921-1923			
	Number of Males Aged 20-65 Years Census of 1921	Registered Deaths of Males Aged 20-65 Years	Calculated Deaths of Males Aged 20-65 Years (b)	Ratio of Registered to 100 Calculated Deaths
	(1)	(2)	(3)	(4)
All males	10,082,062	278,911	275,207	101
All occupied and retired males	9,704,860	266,384	266,384	100
Class I (Upper and Middle)	225,618	5,813	7,048	82
Class II (Intermediate)	1,974,884	54,913	58,205	94
Class III (Skilled Workers)	4,218,715	103,990	109,528	95
Class IV (Intermediate)	1,984,906	53,839	53,475	101
Class V (Unskilled Workers)	1,300,737	47,829	38,128	125

(a) Table reprinted exactly from (O-1) except that all the many pages of data for specific occupations have been omitted, also columns (5) (6) and (7) which appeared to have nothing to do with fertility. A great part of the detailed mortality data has been reprinted by the U. S. Public Health Service, but *none* of the enormous array of fertility figures. See Appendix A for explanation of Classes I to V.

(b) The calculated deaths are those which would have occurred if the mortality rate at each age group in the several occupations had been the same as that for all occupied and retired males. (Note as printed in the original volume).

OCCUPATIONAL MORTALITY, FERTILITY AND INFANT MORTALITY IN GREAT BRITAIN (*Concluded*)

From Registrar General's Decennial Supplement, England and Wales, 1921, Part II, Table A

Occupation	Number of Married Males under 55 Years of Age (Census of 1921)	Legitimate Fertility 1921				Infant Mortality 1921		
		Registered Legitimate Births	Legitimate Calculated Births	Ratio of Registered to 100 Calculated Births	Crude Birthrate per 1000 Married Males under 55 Years of Age	Crude Birthrate Compared with that of all Males Taken as 100	Deaths of Legitimate Infants under One Year	Rate
	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
All males	5,802,922	810,196	810,196	100	140	100	64,135	79
All occupied and retired males	5,710,219	805,345	799,676	101	141	101	63,636	79
Class I	127,157	12,404	14,606	85	98	70	476	38
Class II	1,155,491	120,306	141,806	85	104	74	6,665	55
Class III	2,597,138	365,337	378,042	97	141	101	28,077	77
Class IV	1,139,655	184,358	168,902	109	162	116	16,483	89
Class V	690,778	122,940	96,320	128	178	127	11,935	97

of father at birth of each child and a completion of the Life Table by Social Class in the years of childhood which are now missing. This is the dictum, as we have said, of Dr. Stevenson (S-15), and also of Sir Bernard Mallet. (M-3) Dr. Stevenson is the greatest authority on the subject in the world today, as no one can deny, even though he confesses he has not completely succeeded in his enormous work, "Fertility of Marriage."

We have said enough to show that a differential birth-rate does not necessarily mean a difference in realized fertility. The higher birth-rate among the "lower classes" is increased by their earlier age at marriage, but all the other factors probably act the other way. The birth-rate among the poor is thus set off by their higher mortality, their possibly greater migrations, and in the lowest classes by their marriage rate, which is lower in England. Above all, it may be set off by a possible "passing upward." A certain proportion of each class may have their children born while they are in a class which later they abandon to swell the class above, making the latter's birth-rate appear low so long as they live in it without having more children. Then there is another kind of "passing." It may be that through the centuries strong individuals from ordinary strains forbear having children *for the very sake* of rising to Class I and II. From this no eugenic loss would ensue, unless it were true that the never-born children of these individuals would if born have resembled their fathers rather than their ancestors.

Because the available statistics, except perhaps the Dutch, omit some essential factor, any attempt to unravel the present statistics is only tentative.

If we have labored these *points of possibility* it is because judgment rejects the likelihood that the truly strong are allowing themselves to be defeated and wiped out. It seems to me that the English figures, quoted from Carr-Saunders in a note early in this section, do not contradict the following inherent probability:

Classes I and II are maintaining their numbers by descent, and besides are being increased (as in possibly all ages of history) by "passings" from below. Finally, when these passings are held in mind, it is very difficult to determine: a) whether statistically the residue remaining in the "lower" classes is becoming an increased proportion of the whole; b) whether logically this residue, plus the passings, should or should not be called a disproportionate increase of the lower classes. The point is that the upper classes of *each* generation with which comparison is made never are completely upper class, but merely "upper class plus passings."

Very likely the net increase of society may come from the lower levels; but whether these individuals, born low and ending high, should be labeled "superior" or "inferior" —that is the question! Restated, the question is this: did the workman become boss because the boss failed to father a son, or did the boss fail to father a son because a competitor risen from the ranks pressed him too hard in business—or possibly so pressed his parents when he was growing up and should have been making, with their aid, an early marriage.

By estimating and applying differential mortality rates to column 9 in the Table herewith, one may estimate the deficits which give lee-way for passing. Do we want to

follow India's example and abolish "passings," or do we not?

IS CLASS DIFFERENTIATION A MEASURE OF BIOLOGICAL VALUE?

Let us give way again. Let us suppose not only that rough and ready selection by means of differential fertility can have important biological results, but also that the present differential birth-rate is not counterbalanced by other factors. Let us suppose in fact that existing differential fertility results in biological change. It still remains to prove that the change is in the wrong direction. It will only be so if the qualities which distinguish the upper from the lower classes are more valuable than those possessed by the lower classes. Of course it is widely held that the upper classes are biologically superior, but this is no proof that the view is true. We may be a little suspicious since it is the upper classes who have put forward the view, the lower classes not having bothered themselves much as yet on the subject of biology.

What do we know about biological differences between the social classes? It is essential to discuss the existence of differences first, leaving until later their evaluation. In most discussions these two questions are mixed up. To prove the existence of differences we have certain measurements and also certain inferences that may be drawn from our knowledge of what is going on in society. Among the measurements are the intelligence tests recently applied again and again in every civilized country, with about the same result in nearly all cases. The higher social classes show on the average a slightly higher intelli-

gence. Does this mean that the upper classes are better endowed with intelligence than the lower classes? The tests have been criticised. It has been said that in replying to the questions in the tests it is necessary to use acquired knowledge, which children of the upper classes have had more opportunity of acquiring; also that their nerve structures may be better nourished and protected, from the moment of conception. These criticisms scarcely demolish the evidence, for the tests have been very carefully constructed and administered.

Let us therefore accept these measurements as proving a *slight* average superiority in that kind of intelligence which is measured by the tests among the upper as compared with the lower classes. It is not easy to upset this conclusion. Pearl has recently attempted it in vain. (P-3) He has considered the evidence provided by information as to the occupations of the fathers of the forty-eight most famous philosophers. If the conclusions we draw from the intelligence tests are valid, then the fathers of these very clever offspring should come from the upper rather than from the lower classes. Pearl says that this is not the case. "Taking the list of fathers (of the 48 most famous philosophers whose fathers' occupations are recorded) as a whole, it is perhaps as fair a cross-section of men in general as one could expect to attain in a sample of 48. It is mainly composed of mediocre people, with a few superior persons in the lot, and a few badly inferior." *But Pearl's statement will not bear examination.*

These forty-eight occupations are far from being "a cross-section of men in general." Below is Pearl's list. In the column on the right, which has been added, the

occupations are allocated to the Social Class in which they belong according to the method of classification used by the British Census prior to 1921.[8] (F-2, Table 34)

Petty political office-holders	6	I
Higher political office-holders	5	I
Merchants and shopkeepers	4	II
Lawyers	4	I
Clergymen of small parishes	4	I
College or university professors	4	I
Physicians	3	I
Watchmakers	2	II
Weavers	2	VI
Farmers	1	II
Peasants	1	VII
Of titled family	2	I
Soldier	1	IV
Citizen of London	1	V
Saddler	1	III
Illiterate and criminal	1	V
Manufacturer	1	I
Clerk	1	I
Shoemaker	1	III
Fisherman	1	IV
Historian	1	I
Schoolmaster	1	I

This shows 32 fathers in the highest class, 7 in the next, and 2 each in all the other English classes, except VIII (miners). But if "men in general" had really produced these famous philosophers; that is, if every class had produced proportionately to its numbers as represented in the England and Wales of 1911 (F-2, Table XXXIV), the highest class would have produced only about 5, the second class a little more than the number it actually did produce, and all the other lower classes would have had

[8] See Appendix A for description of these classes before 1921, and since.

to produce the balance of the 48 philosophers—namely, 36. In reality, the 6 lower classes produced only 9 instead of 36, and probably fewer; to get 9 we labelled "a citizen of London" in the day laborer class V, and so forth. The highest quarter of the population, Classes I and II, produced more great philosophers than are to be numerically expected from all the lowest three quarters.

In fact, the data upon which Pearl relies to disprove the results of intelligence tests are a support for them. Let us accept them. What other measurements have we got? There are very few. Intelligence is only a part of human mental characteristics, but there are as yet no means of measuring the other parts. Then there is physique and health. There are some measurements of these characteristics, but nothing like as many as of intelligence. One of the most extensive of these measurements was made during the war in connection with recruitment for the British army. Thousands of men were measured and it was found that miners and agricultural laborers had better physique than other members of the working class. (P-16, pp. 142, 231) But miners and agricultural laborers have the highest birth-rate, and it would seem that in their case differential fertility is working in favor of good physique though it is not working in favor of good intelligence.

When measurement fails, we can turn to inference. We know what is going on in modern society. Men are not tied down to the class in which they are born. They can make their way "upwards" and the chief characteristic required for upward movement is ability to achieve commercial success. Large numbers do work their way

upwards presumably because they are lucky or because they possess more than the average amount of intelligence, or both. But need those who work up and fill the ranks of the upper classes possess other qualities in a greater amount than the average? What about artistic capacity, musical capacity, compassion, cheerfulness, a mystical sense of religion, and so on? There is certainly no need for the possession of more than the average amount in order to achieve success. On the contrary, musical genius, unless it can be turned to commercial use, may be a positive hindrance. So too may be compassion, an instinct to turn aside from one's own affairs and help others. In fact, for success under the modern competitive system, there seems to be required a certain narrow quality of quickness and intelligence and an absence of other qualities, or at least a limitation of their development beyond the point at which they begin to be embarrassing. However, Professor Terman found disposition as well as health to be inferior among lower class children. But, as in the matter of intelligence, the doubt remains whether this may be from defects of nutrition and other environmental conditions, from conception onward.

Such are the attempts by measurement and inference to ascertain the inherited differences between the classes. Now what value shall be given these differences? This is more difficult still. How weigh an excess of intelligence against a possible excess of altruism and other qualities, with physique uncertain? It would therefore seem to be premature to assert that when *only* inherited characteristics, and of them, *all* are taken into account, the upper classes are on the balance superior to the lower classes.

Finally, the comparison of class with class may be abandoned, and individuals within each class compared. That is, the broad objection may be taken up, that birth control will always be more practiced by the cautious parent of whatever class than by his careless brother. Hence, caution will be bred out of the race; also any qualities always linked with caution. The answer to that has been indicated in the preceding paragraphs, and is, that caution is merely one valuable quality among a hundred others The whole tendency of civilization appears, in the eyes of some philosophers, to be urging men to remain too cautiously in their routine. It may do no harm to have one single force decreasing caution. As to qualities linked with caution, the burden of proof is upon the objectors to prove that there are such.

DO CLINICS MAGNIFY THE DIFFERENTIAL BIRTH-RATE?

Once more let us give the case away. Let us admit for the sake of argument that not only can considerable biological changes follow a differential birth-rate, and that the present differential birth-rate is not counterbalanced by other factors, but also that the upper classes and the cautious types of men are biologically superior. It still remains to show that the clinics increase the gap before it follows that their influence is dysgenic.

The fear that the influence of the clinics will be dysgenic is based upon the assumption that their propaganda will appeal to the superior, the thoughtful, and the provident —those who desire the best for their families; whereas the careless and improvident will be untouched. This is a reasonable assumption as to the effect of the spread of

knowledge when it is new. It probably does get taken up first by the most desirable classes and individuals. But clinics have not come into the field bringing this knowledge as a new thing in itself. They have come to bring it to all. Suppose, therefore, that the desirable possess it already and will not apply it further, the effect of the propaganda will be to spread the knowledge and the use of it among the less desirable. Chapter IV has shown that the clinics are thus ministering to the day laborers especially.

This is the point of view of the English eugenists. They think that the upper classes have reached saturation point in their capacity to absorb more of this propadanda. It is an old story to them, and few have more children now than they have rationally determined upon. If a birth takes place accidentally, it often merely antedates a birth that would have taken place a few years later. The ultimate number of surviving children is predetermined. The effect of propaganda, therefore, can only be to decrease and not to widen the gap. It will be eugenic and not dysgenic. Newsholme says that it is "highly improbable that the poor mother will not follow the example of the well-to-do." (N-6, p. 54)

These are assumptions and we may ask what the figures show. In England the fertility of the lower classes is already below the physiological natural fertility; their young wives show only one-third of the fertility of their age and class in 1870. (F-2, Tables XLV and 24) (M-23) (L-5) Dr. Stevenson, though convinced that the gap between the class fertilities widened for many years after 1850, admitted that his figures showed a narrowing of the gap since the turn of the century. From France, we

have interesting studies showing that, when an epidemic has swept away many children from a town, there is a rise in the birth-rate in the following year. (M-5, p. 249) Clearly, measures have been taken to replace the loss. The situation is almost wholly under control. In France, where knowledge is so widespread, employers have, according to March, "notably more children" than their salaried employees, though the latter have fewer children than wage earners have. (M-5) (J-5) A very wide extension of knowledge therefore tends to put the upper classes in a favorable position. Further, one is able to deduce from March's arrangement of official French figures (p. 262) that the wage earners' birth-rate is falling faster than that of the salaried man, as follows:

Clerks, birth-rate for marriages of over 15 years..... 237
Laborers, birth-rate for marriages of over 15 years..... 307
Clerks, birth-rate for marriages of over 25 years..... 285
Laborers, birth-rate for marriages of over 25 years.....385

Note that these figures show that the laborer's birth-rate is falling faster than that of the clerk. The recent marriages of laborers show a fifth less children, whereas those of clerks show a sixth less, than those of earlier date. The fact that laborers marry at an earlier age than clerks would have led one to anticipate just the contrary.

Propaganda has been loudest and most long-continued in great cities, especially in the north of Europe, and accordingly it is not surprising to find the workmen's birth-rates rapidly dropping to the level of the upper classes in London, Berlin, Dresden, Hamburg, Zurich, Prag, and Oslo. This is the statement of the conservative professor Julius Wolf. (J-4) Dr. Edin's study shows a stand-

ardized legitimate birth-rate for the upper classes in Stockholm, thirty-one per cent higher than for the industrial classes. (E-3) This study may be criticised in many ways,[9] but taken in conjunction with Wolf's statement, it suggests that the English eugenists were justified in their expectation that a sufficiency of propaganda can abolish the differential.

As additional evidence, the Australian figures on average issue of males according to occupational grades given in their census for 1921 will repay examination, although the method of dividing the population into social classes according to manner of employment is far from ideal for the study of differential fertility. The first portion of a table from the Australian census (C-3, Table 8) is reprinted herewith. There are three grades:

(1) Employer
(2) Working on own account but not employing labor
(3) In receipt of wages or salary

The trouble is this: the employer grade is not wholly upper class because persons low in the social scale may em-

[9] Points to be cleared up: Why speak of a crude fertility rate of 11.2 for Stockholm as being so "remarkably low"—in comparison with that in other *countries?* A capital city commonly has a far lower rate than a whole country; Berlin dropped to a rate of 10.0 about 1926 according to Grotjahn. (P-16, p. 149) Why standardize (E-3, Table 3) "*for marital condition*" the birth-rate to *all* women fifteen to forty-five years of age? Finally, why standardize at all for age-and-duration-of-marriage when dealing with differential class fertility? See italicised words earlier in this chapter; also Chapter VIII. The Edin article would be more valuable if it included crude birth-rates by classes, conjoined with nothing more than a statement of changed proportions of reproductively vs. non-reproductively aged females. Finally, the chief omission in the data is the age of the parents at birth of the children.

AVERAGE ISSUE ACCORDING TO OCCUPATIONAL GRADES AND AGE

Abstract of Table 8, Census of Commonwealth of Australia for 1921, Part XXVIII entitled: "States and Territories:—Average Issue of Husbands (a) classified according to occupation in conjunction with grade of occupation and age."*

Age by Five Year Groups	Grades, All Occupations			
	All Grades of Occupation (b)	Employer	Working on Own Account but not Employing Labour	In Receipt of Wages or Salary
All ages	3.38	3.55	3.79	3.02
15–19	.58	.80	.50	.59
20–24	.80	.70	.76	.80
25–29	1.32	1.24	1.28	1.34
30–34	2.06	2.02	2.09	2.05
35–39	2.77	2.71	2.91	2.75
40–44	3.40	3.29	3.63	3.37
45–49	3.91	3.83	4.21	3.83
50–54	4.34	4.35	4.64	4.25
55–59	4.86	4.93	5.13	4.79
60–64	5.42	5.56	5.76	5.36
65 and over	6.47	6.84	6.74	6.00

* Original heads and figures as given except for rearrangement to fit paper. Eight main classes, such as professional, domestic, commercial, etc. and 36 specific occupations within these, omitted, only grades for all occupations jointly, retained.

ploy a helper. The third grade is not wholly lower class because some salaried managers will be receiving high salaries and earning an income in excess of that accruing to many employers. However, the number of highly paid salary earners must be small, and it is doubtful whether their inclusion seriously affects the birth-rate figure of the class when it is taken as representing the birth-rate of the wage earners. The second grade is the least homogeneous. It contains well paid professional men working on their own, as well as odd-job men in a very small way of business or none at all, and farmers working with only family help at most. Obviously Grade Two represents no one social class. We may legitimately take Grade One as upper class and Grade Three as lower class, but we had best leave Grade Two out of account. It has the highest birth-rate. This may be due to the inclusion of small farmers, to whom society does not grudge large families, but also of unemployables, who are a far less desirable strain.

If we concentrate attention upon the employing and employed classes and look at the column giving the average issue of husbands for all ages, we note something similar to that found in the case of France. The employing class has the higher birth-rate. This rate may be forced up by the inclusion of low grade employers with a single employee each. The rate for the wage earners may be forced down by the inclusion of highly paid salary earners, corporation managers and so on. But allowing for defects in classification, one estimates that the birth-rate of the upper classes is no less, and is probably greater, than that of the lower classes. But this conclusion is based

upon the figures for employing and employed classes only. Those working on their own account are excluded and, since they have the highest birth-rate and may be lower class in the main, it is premature to say with Benham (B-36, p. 23) that "the difference in the birth-rate between different [Australian] social classes is inappreciable." It is necessary to remember Siemen's warning that very slight differences may have important results: "If the relative number of children" are "as close as 3.3 to 3.4, that is, as 1:1.03 . . . after about 774 years the numbers of the favored race will be double those of the other race." (S-11, p. 89)

And it is also most important in all this question of class increase to emphasize "turn-over," the age at which each class has its children. This, many writers fail even to mention.

So, let the humble realization dawn upon us that we know scarcely anything about relative class increase, now or in the past, or whether there has been a change or no.

SUMMARY

The object of this chapter is to defend the clinics against the charge of exerting a dysgenic influence. It is very important to see where the argument, in four stages, has led us. In the first stage it became apparent that biological change, either for the better or for the worse, eugenic or dysgenic, is more difficult to bring about than is usually supposed. The argument is not that unfavorable changes are never to be feared or that it is useless to work for favorable changes. The argument is merely that certain factors are often held to be capable of pro-

ducing rapid changes when such is not the case. In the second stage we passed from general to special considerations and showed that the existing differences in the birth-rates of the different classes may be counterbalanced to a large extent by differences in the death-rate and four other factors. In other words, what is important is the net result of birth-rate, survival-rate, marriage-rate, age at parenthood, and other factors, and to take the birth-rate by itself is nearly certain to be misleading. In the third stage we raised the question of the biological value of the different social classes and showed that the superiority of the upper classes could not be taken for granted. In the fourth stage we showed that the influence of the clinics is likely to be in the direction of diminishing rather than increasing the difference between the class birth-rates. There is a general sea-level towards which birth rates in all classes are tending.

As to the individuals who may be so incautious as to maintain islands of high birth-rates rising above this sea-level, no doubt society, getting such a clear view of them, will know whether it wants to preserve their stock or to extinguish it.

We believe the defense to be complete. Leading American eugenicists like Popenoe, Johnson, and Whitney (P-11) (H-10) have no fear that the clinics will exert a dysgenic influence. Such a fear has only the flimsiest foundation.

But to reach this conclusion is not to minimize either the possibility of eugenic improvement or the importance of eugenic propaganda. Though it is not proved that any degeneration is taking place in our race or is even soon to occur, this does not prevent the possibility of *re*generation.

Eugenics may still be the most important word coming to our ears. Some race may presently make an overt and conscious effort towards its own improvement by breeding. Such an effort would, if successful, be the most interesting event that could occur on this planet and to all other races possibly the most menacing, or perhaps the most stimulating, occurrence that it is possible to imagine.

CHAPTER X

WHAT BENEFITS CAN ONE EXPECT?

It is not wise to claim a cure-all in any field. Also, the greater the claims that are made for any novelty, the more they demand careful examination.

The benefits which have been at various times anticipated from a general adoption of birth control, fall into two classes: The simple, direct benefits and the problematical group connected with pressure of population.

The latter benefits can descend upon us only through absolute decrease of the present population or else from slowing its growth sufficiently to let the growth of the arts outstrip it. This group includes:

Fewer wars
Higher wages
Less unemployment
Lower land rents

These benefits are problematical in three ways. In the first place, as shown in Chapter VIII, serious students can make out quite a good case against the likelihood of population pressure being lessened sufficiently to lead to these benefits.

Secondly, therefore, birth control advocates should ask themselves whether, considering this uncertainty, it is wise to put forth claims which antagonize many who are not desirous of lessened pressure.—Or, to put it in another way, is it worth while to mention high-flown dreams and visions which may cause earth-bound men to reject a

program leading to sure and concrete goals—to the simple, indubitable benefits which can be gained by birth control?

Finally, impartial thought admits that there would be some real problems coincident with each benefit from lessened population. These antagonistic views and four coincidental problems may be roughly summarized as follows:

(a) Some believe that a nation with a stationary population is in a bad biological or psychological state, or in a bad position to defend itself should need arise.

(b) Higher wages resulting from lessened population would involve a shortage of "hands."

(c) A smaller population would depress real estate values.

(d) If there were no reservoir of the unemployed it would be necessary to develop a technique for supplying the great seasonal industries. However, the connection between pressure of population and unemployment will be found very tenuous and scarcely worth tracing by debaters on either side.

Accordingly, to declare that birth control can do much to decrease population and relieve pressure is premature, to say the least, and raises up unnecessary enemies and problems.

THE PLAIN BENEFITS

The direct and certain benefits of the birth control movement, and particularly of the clinics, have an essential simplicity resembling the work of anesthetics in

surgery. Four definite sources of human misery can be permanently reduced:

Undue postponement of marriage
Abortions
Sex strain, if not outright dissension, between husband and wife
Supernumerary offspring conceived only to die after agony to themselves and the mothers

These four evils do not sound, perhaps, very impressive. Their great significance is that they spare no one. It would seem that two or three of them on the average attack every human pair. Their numerical significance is incalculable.

Through the cure of these intermingled mental and physical evils, family life can be immeasurably relieved of bitterness and quarreling. The case-workers who deal with thousands of domestic relations cases—separation and desertion and non-support,—at the Municipal Court of Philadelphia declare that disturbed physical relations and the lack of birth control are the commonest difficulties.[1] These have always been great difficulties. When Shakespeare's twins were born, making three children in the first eighteen months or so of marriage, he decided to leave for London and produce plays instead! As one reads the biographies of those days, Holbein's for instance, one often observes this custom by which great men freed themselves for things more worth while than unlimited child-rearing. The Nobel Prize novel *Kristin Lavransdatter* gives a fictional picture of the saving of a young wife's life because her husband has been wise enough to go

[1] Statement to the author by Dr. Louis N. Robinson, formerly Chief Probation Officer, Municipal Court of Philadelphia.

away for two years on a Viking cruise. Contraceptive measures would be a kindly substitute for this drastic and somewhat impractical policy.

Then we must realize what a great thing it is to help people in such straits as the one who wrote to the American Birth Control League in this wise: "I am a girl eighteen years old always with the back-ache since I was a little girl and can hardly take care of the one baby I have as she has fits and my husband who is forty-three has never held a good job." The League receives hundreds of letters like this every year. (S-2)

To sum up, birth control is essentially a powerful aid to mental and physical hygiene.

REDUCING THE NEED FOR CHARITY

Let us also examine the probable direct effect of birth control on charitable work. The great burden of charity cases may be divided into those involving:

(1) Old age
(2) Illness
(3) Unemployment
(4) Ill-treated, neglected and dependent children
(5) Too many children for the parents' wages
(6) The unemployable and unfit

Of these items, old age alone may seem not to be aided by birth control, though it is the pressure of new young workers that makes old age a difficulty earlier and earlier encountered, many industrial workers today finding it difficult to obtain employment after the age of forty.

Among illnesses, women's and infants' diseases will be directly reduced. The United States Children's Bureau

has not hesitated to say that infants born at a short interval after others have "a markedly higher mortality than other infants" even after allowance has been made for nationality, fathers' wage, artificial feeding, and four other factors. (W-9, p. 67) But the effect of such fundamental improvement among mothers and infants cannot stop there. Infants' future constitutions and hard-working parents' later health will improve. Since illness and unemployment are vicissitudes which the populace will become stronger to withstand, and with less outside aid, if health in earlier life has been carefully promoted, we maintain that birth control will lessen the burden imposed upon the community by all illnesses and also by unemployment.

The fourth and fifth items bringing children to the charities—cruelty, neglect, and poverty—will obviously become lighter burdens as soon as the number of unwanted offspring is lessened.

The last item, the problem of the unfit, will be aided in one way—possibly in two. Intellectually, it is an unsolved problem. More attention can be given it wherever philanthropy has been relieved of some of the children's cases and illness cases, as described. Secondly, there is a possibility that this problem may be lessened by the transfer of fertility described in Chapter VIII. That is to say, it may be that in recent times the unfit have been coming largely from those who still have been indulging in big families after most folk ceased to do so. Therefore, if the clinics can enable these people to have, say, four children instead of eight, the number of the unfit will be cut, not in half, but perhaps nearly in half. (L-2)

We have compared birth control in its simple, direct results to an improvement such as the invention of anesthetics. But just as anesthetics can have little effect on the fundamental problems of health, so it is possible that birth control cannot end, but can only slightly retard the increasing pressure of population. It is a tendency of the human mind to be too much impressed with a novelty. Thus it was urged against anesthetics that they would abolish from the world the discipline of all pain. But in the outcome quite sufficient mental and other suffering has remained and the suicide rate is no less. This illustration shows how much surer we can be of simple, direct results than of sweeping universal changes such as the abolition of all poverty and pain or the end of population growth.

FOR THE SAKE OF HAPPY CHILDHOOD

Of all the results to be hoped for from birth control, the best is this: that it should do its part towards making all children healthy and beloved. Let us hasten the day when every little round cheek will glow with the soft, downy look of health.

It is no light thing to have fewer children than one might. It is not without a pang that one thinks of a child one might have had. But realities are sadder than visions. A mother knows many a time within her soul that a child, if it should come just then, would not have much chance to he healthy or happy. This is a reality. The mother's soul reacts to it. Deep within, she knows she should not bear this child, much as she would have loved it. This is as plain to her as any black or white or wrong or right there is.

But our society does not allow her to refuse her husband because of this. It allows him, as a penalty upon her if she refuses his embrace, to divorce her. That involves a deluge of risks. Possibilities of disgrace and of losing her children to him are added to the certainty of having to set up a much more modest home, lacking both the man and the prestige which his personal income is able to secure.

Society must resolve these contradictions of law and conscience.

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APPENDIX A

PATIENTS' SOCIAL STATUS

Most special clinics have on hand the raw materials of ammunition to meet the common charge that they accelerate the differential in the birth rate, for practically all ask questions of the patient intended to reveal social status. Status in the public clinics is also summarized below.

Case Sheet Inquiries. Of course, it is not easy to get accurate answers. The patient sometimes magnifies her *income* out of vanity, or on the other hand deflates it in order to get the treatment cheaper. She misrepresents her husband's *occupation* out of inaccuracy or vainglory, saying perhaps, "he works at boiler making," when he merely sweeps out the plant. "Occupation" gives one of the hardest sets of replies to tabulate. Questions on education are useless for foreign-born women. For communities where education has been really compulsory, the best single index is age and grade on leaving school. "*Number of rooms*" is misleading because answered in the same terms by women living in a few rooms either in a fine residence section or in a slum; "*rent paid*" similarly may be very high because it may be for two rooms close in, or for fourteen rooms far out of the city. "Do you have a *private bath?* and *toilet?*" is one of the best questions to reveal social status (and the prescription may depend on the answer). In a score of clinics, summaries from these questions have reached the stage where they can be used as statistical ammunition.

Special Inquiries on Health and Heredity. The short Stopes sheet goes into family health history. And, like the record forms of Walworth, Detroit and Los Angeles, and those of the Committee on Maternal Health, it asks something about the causes of death of any off-spring whether prenatal or later. Vienna asks how many children have inherited disease.

Los Angeles (No. 57) inquires into the health of parents and siblings on both sides; illnesses and operations of applicant and her husband; their children's health, age, weight, and any special examinations or special care ever given them. Originally the Los Angeles form specified *grandparents* and *cousins*, but the later form has been simplified after experience. These data would seem to provide a field for geneticists

and other scientists, especially now that the clinic has been liberally endowed, and may be able to coöperate with research.

Accuracy on the Continent. In Germany, the clinics of the Bund (Birth Control League) and of course all the municipal clinics in Table I are exactly informed about their clients. They examine the police ticket carried by each person which officially describes the bearer's or her husband's occupation, insurance and employer. In Vienna (Nos. 17 to 24) only wives of unemployed men are taken free, and this fact is confirmed from the police ticket.

Occupational Data. Figures on occupation are elusive, as all workers know, and as usually gathered are extremely difficult to handle statistically. Two major purposes are served by securing an answer to the case sheet; to identify the family and for staff use in case handling; and secondly, to make possible the later classification of the husband as:

Unskilled
Semi-skilled (doubtful whether really skilled)
Skilled
Clerical and intermediate
Professional and managerial

More ambitious attempts are liable to land the statistician in a swamp of categories, made up of scores of occupations with only a few instances of each.

Wage Data. The wage and income data below are given in groups too large to be very useful in working out the relative proportions of social classes represented. Moreover, wage and *not income* is what should be taken for this purpose because: a) wage is a good social label and not, like income, dependent on accidents of illness and unemployment; but b) to take income for this purpose leads to an insuperable difficulty through lack of any known scale of family income or income for adult males of the particular locality with which to make comparisons. The National Bureau of Economic Research figures are entirely unsuitable to use as a standard for clinic husbands because heavily laden with low income receivers of the female sex and ages under eighteen.

The "husband's weekly wage when working" should be entered preferably to the nearest dollar, (or monthly, or yearly, wage if that is the way the client thinks of it). This accuracy is required if much headway is to be made in differentiating the artisan from the unskilled. In general, the original records should give occupation and wage data as

explicitly as possible and leave the task of grouping for statistical purposes to the student.

Every unskilled worker should be recorded as such, and the details of occupation or wage or both should be so entered that this fact appears.

Occupations in English Clinics

In the accompanying Table VI on "Occupational Distribution of Birth Control Clients . . . ." are given the figures gathered by Mr. and Mrs. Himes for nine English clinics, all but one in Table I, and comprising records of 3207 husbands with nature of occupation given in 2915 cases. For purposes of comparison the distribution of the general population as given in the English census is added. (O-1, p. viii)

England has had for some time a grouping into occupational classes more useful for our purpose than the U. S. Census Code, in that general social and economic grades are indicated in a satisfactory manner. In 1921 a further improved classification was adopted (S-15) and in the census of that year the general character and distribution of *employed and retired males* was as follows: (O-1, p. viii)

Social Class Designation	Specimen Occupations	Percentage in Population 1921
Class I, Upper and Middle	Nobility, professional and mangerial, higher public service	2.33
Class II, Intermediate	Occupations "indeterminable" (S-15) whether Class I or skilled. As: farmers, most merchants, navigators	20.35
Class III, Skilled Artisans	As: carpenters, waiters, tailors	43.49
Class IV, Intermediate	Occupations "indeterminable" whether skilled or unskilled. As: barmen	20.45
Class V, Unskilled	As: laborers, porters	13.40

As Mr. Himes did not use this classification in his original report, it has been necessary to compile Table VI from his source table. (H-3, Table II)

TABLE VI

Occupational Distribution in Birth Control Clinics Compared with General Population in England and Wales

Based on occupations reported for 2915 husbands in nine clinics
Sources: Himes (H-3) and English Census (O-1)

Location of Clinic	Total Cases	V Unskilled	IV Intermediate	III Skilled	II and I Two highest Classes
Distribution in Occupation Classes					
Wolverhampton	479	63	28	(368)?	(20)?
Birmingham	150	40	23	66	21
Manchester	531	196	86(a)	186	63(a)
Glasgow	139	52	27	37	23
Cambridge	263	99	53	78	33
North Kensington	898	379	94(a)	281(a)	144
Aberdeen	98	42	8	22	26
Liverpool	215	109	38	46	22
Cannock	142	142	—	—	—
Clinic Total	2,915	1,122	357	1,084	352
Per Cent Distribution					
Wolverhampton	100	13	6	(77)	(4)
Birmingham	100	27	15	44	14
Manchester	100	37	16(a)	35	12(a)
Glasgow	100	37	19	27	17
Cambridge	100	38	20	30	12
North Kensington	100	42	10(a)	31(a)	16
Aberdeen	100	43	8	22	27
Liverpool	100	51	18	21	10
Cannock	100	100	—	—	—
Total Clinic Per Cent	100	39	12	37	12
Percentile Division in 1921 Census England and Wales	100	13	20	43	23

(a) Figures for two categories originally combined by Mr. Himes in single figure redistributed according to average proportion in remaining clinics.

The last rows of percentages in Table VI may be compared and it will be seen that the largest class represented in the clinics was the unskilled which averaged 39 per cent as compared with only 13 per cent of unskilled present in the general population. In only one clinic did it fall to the level in the nation. Figure 1, in Chapter IV made from Table VI, shows all very plainly.

If by examining the source figures the dubious effort is made to split up the 12 per cent of "Two Highest Classes" in Table VI into the component Classes I and II, it appears that 4 per cent were in the topmost class. This is twice too much for Class I but leaves Class II very deficient at the clinics, as are also the other classes between the two extremes. Class I forms such a small part of the nation (only 2 per cent), and was so certainly limiting its birth-rate already, before the invention of clinics, that there can have been little or no effect on the nation because Class I attended the clinics.

Occupations in U. S. clinics

Among 419 husbands of two Illinois League clinics at Chicago, 25 were unemployed and for 73 the occupation was not recorded. (Y-1) For the 394 recorded, the distribution is here given with figures also for 168 Baltimore husbands whose wives attended No. 65.

	Per cent	
	Chicago	Baltimore
Unskilled	24	18
Skilled	56	53
Intermediate	—	23
Professional and Managerial	20	6

These are figures for the first year or so only at both places and at present a much lower range of patients is probably treated. See Chapter IV. The figures are not exactly parallel for the two places in that Chicago probably includes clerks and tradesmen in the skilled whereas Baltimore names them and also 8 per cent of farmers. All these and also 2 per cent of unknown cases we have lumped under "intermediate 23 per cent," for Baltimore. (These three named groups are Class II in England.)

Chicago shows, more than Baltimore, the tendency, noted for England, to excessive representation at each end of the social scale. This is

because Chicago like England takes patients for economic reasons as well as health. But Baltimore takes only for health reasons and the direct (in so far, dysgenic) result is that it gets fewer unskilled, indeed, none of the unskilled whose only malady concerns their income. Class II is also for the same reason possibly larger at Baltimore than at clinics taking patients for any and all reasons.

The excess of the professional and managerial class at these clinics when very new, particularly Chicago, has been fully explained and defended in Chapter IV. A number of the "professional "patients at Baltimore were University colleagues of the group founding the clinic.

It remains to consider how satisfactory is the ratio of unskilled at these two clinics. They compare pretty well with the unskilled in the general English population—see the Figure in Chapter IV—inasmuch as the 13 per cent of English unskilled have to be augmented by part of the Intermediate IV. It is unfortunate that we have no very good American standards with which to compare them. Coombs (C-7) gives the following estimates of the United States Unskilled:

Walling (1904) considers two-thirds of United States male labor unskilled. Nearing (1911)—50 per cent.

Edwards, in Volume XV, Journal of the American Statistical Association, working on Thirteenth United States census; and

Coombs himself, allow about one-third of the total male employed as unskilled. (Edwards and Coombs are later and very careful students.)

But their estimate of one-third which includes all males of all ages must be cut down if one tries to use it to compare with clinic figures, because clinic husbands, being city men, come largely from manufacturing and mechanical industries, and from older age groups and in none of these categories is there as much unskilled labor. A great deal of the unskilled labor in the general population is among persons under 18 years old. In manufacturing and mechanical industries Edwards drops his per cent below 29 (all ages, city and rural).

Hence, one estimates that city-living, married males over 18 are not much *more* than 24 per cent unskilled, and feels satisfied to say that the Chicago clinic by treating 24 per cent of unskilled is reaching this class in adequate, possibly more than adequate, proportion.

WAGE STATISTICS

Wage figures for birth control patients are yet more recalcitrant than those for occupation, and a standard for the general population is even

in bare prospect in California alone. Unfortunately, at all three clinics, income or wage receipts and not wage rates were usually inquired for, thus precluding the fitting to a standard and furnishing, as stated at the head of this chapter, a much poorer label for eugenic purposes.

Los Angeles. The examination of the case-sheets at No. 57 made with the kind coöperation of Paul Popenoe, from the beginning of the clinic to date of January 5, 1929, covered a total of 2,589 cases for which the wage was stated in only 1,118 cases. Dr. Paul Popenoe says, "I do not know whether there has been any selection at this point, tending for example to include a disproportionate number of the low-wage people, or vice versa; but from questioning the clinic people I could see no indication that there had been such a selection." He fitted the following data to a normal curve to see whether they appeared to be "loaded," but they did not. The real trouble is that no settled policy seems to have been followed as to asking for wage rates or merely wage receipts.

Husband's Weekly Wage	Families	Per Cent	Cumulative
Under $12	17	1.5	
$12 to $23	321	28.7	30.2
$23 to $35	562	50.2	80.4
$35 to $46	180	16.1	96.5
$46 to $58	29	2.7	99.2
$58 and up	9	0.8	100.0

In Table VII for "Wage Distribution of California Male Wage Earners Over Eighteen," there is shown an excellent standard for the general population prepared from the official figures of the state. Clinics so fortunate as to be situated in a state with such available statistics as these have a fine opportunity to demonstrate in what proportion they are reaching the skilled, the unskilled and others. They should enumerate "wage-earning" husbands separately from other income receivers (on whatever basis is used by their Bureau of Labor Statistics), should record the *weekly wage rate when working*, and then should tabulate by the intervals in Table VII so that comparisons may be made therewith. Clinics in states where wage rates are not published separately for males over eighteen cannot attempt any of this. Though the wage statistics at Los Angeles are thus inconclusive, other evidence is significant as need be to show that the patients' husbands were "unfit" to struggle with

TABLE VII

WAGE DISTRIBUTION OF CALIFORNIA MALE WAGE EARNERS OVER EIGHTEEN BASED ON REPORTS ON 155,005 INDIVIDUALS

From the 21st Biennial Report of the Bureau of Labor Statistics of the State of California, 1923–1924, p. 129

Weekly Wage	Per Cent	
	In Each Group	Cumulative
Under $10	0.6	—
$10 to 15.99	1.2	1.8
16 to 17.99	1.4	3.2
18 to 19.99	4.0	7.2
20 to 21.99	7.3	14.5
22 to 24.99	14.9	29.4
25 to 29.99	20.2	49.6
30 to 34.99	19.5	69.1
35 to 39.99	14.5	83.6
40 and over	16.4	100.0

the present state of society. Three quarters were employed only half their time and the same proportion were in receipt of relief.

NEW YORK. The data for No. 40 are by family income not wage, for the year 1925 and cover 1584 known cases among 1655 total. (S-21).

Weekly Income	Families	Per Cent	Cumulative
Under $20	150	9.5	
$20 to $30	343	21.7	31.2
$30 to $40	467	29.5	60.7
$40 to $50	238	15.0	75.7
$50 to $100	265	16.7	92.4
$100 and over	121	7.6	100.0

This range is far higher than in the Los Angeles clinic, as might be expected in a clinic treating for medical reasons only as does New York.

The patients of the following year in New York were differently summarized: on "husband's maximum salary when working." But little difference appears in the three percentile figures which alone are given

in the manuscript report. They remained the same as in the preceding table for "family income" except for a slight movement toward treating a lower range.

NEWARK. The first 200 cases at No. 68, (as is to be expected at a brand-new clinic to which the acquaintances of the founders flock at first) had a slightly greater proportion than New York "over $50 family income" but on the other hand, the lowest income classes were wonderfully represented as shown (H-2):

Weekly Income	Families	Per Cent
$25 and under	103	51.5
$26 to $50	38	19.0
$50 and over	59	29.5

According to the authorities (N-1) (C-7), $26.51 marks the limit of highest unskilled wage and 50 per cent is, as we have said, far more than probable proportion of unskilled in the general population group to which clinic husbands correspond for age and location. However, the differentiation of skilled who were treated, from unskilled would be plainer if more than one group under $25 were tabulated.

Cleveland also has many patients of very low income.

ENGLAND. At North Kensington (H-4), no wage higher than $25 weekly was recorded in the first thousand cases, and less than one per cent ran above $15.

The average wage at Birmingham was 2/5s (about $11).

It was stated to me at both the great London clinics (Nos. 26 and 27), that the wages of their clients ranged between $10 and $15 weekly—"with a few higher," it was added by the accurate Mrs. Fuller at Walworth.

VIENNA. The average wage was $5 weekly during these post-war years of work among the poor.

ADDITIONAL EVIDENCE

GERMANY. In twelve of the German clinics surveyed, the staff includes a social worker—which suggests the class of patients dealt with. (N-4) Concerning Frankfurt, Table IV shows a suggestively high average fertility. (In general, Table IV gives evidence on social status in fifteen clinics.)

Moscow. Clinic No. 25 is for wives of factory workmen. In present-day Russia this may be no special eugenic evidence.

Public and Quasi-public Clinics. Then there is a group of twenty-five public and philanthropic institutions which, as shown in Chapter IV, guarantee by their very nature the type of their patients. Among these are the New York, Chicago, Denver, Cincinnati, Atlanta, and Pasadena hospital dispensaries, two Jewish social services and a number of California public health centers. From the Los Angeles group of nine centers it is reported that one fifth of the patients had no incomes and one third less than $100 a month.

SUMMARY

Evidence of one kind or another concerning patients' social status has been given for all but about a dozen of the clinics surveyed.

By examining data from the Los Angeles clinic this large center is found to be treating persons of a very low economic state.

In the remaining clinics statistics indicated with exactness only the proportions of "unskilled" and of "upper class" patients as follows:

The unskilled contribute more than their proper proportion of the clients in the nine English clinics and in Newark; a due proportion in early Chicago and possibly in Baltimore. In England, Chicago and Baltimore the proportion of "professional and managerial" (Class I) is in excess of its ratio in the general population though tiny in actual numbers. In England the deficit of all classes between the two extremes appears demonstrated.

APPENDIX B

PRESENT AND COLONIAL FERTILITY COMPARED

The total white births in 1925 in the registration area of the United States are given in Table VIII, arranged by order of births. (U-2) (See Fig. 3, Chapter VIII.)

If now the same number of mothers had been of a colonial fertility they would according to Lotka (L-5) have averaged annually twice as many births, or 3,204,002 births, though of course no more first births and probably not more than twice as many twenty-fifth births.

While we can not know how colonial births were distributed among the orders, the figures on the right of the accompanying table show a hypothetical distribution. If the figures in this column for the first four orders are kept as low as here shown, which is the same as assumed on Figure 4, curve $a^1 b^2 b^3 b^4$, then it is difficult to accomodate in the whole distribution the total 3,204,002 births. However, it has been accomplished: by keeping per cents of decrease at about 10 per cent only until the eighth order is reached, which in turn necessitates beginning 50 per cent decreases at the thirteenth order, not far from where they began in the actual distribution in the left column. In actuality in 1925, 30 per cent decreases began at once after the second births.

The conclusion we have been aiming at is this: if the first four hypothetical figures had been scaled down yet further (and the points placed lower on Figure 3) then it would not have been possible to accommodate the whole 3,204,002 births of a "colonial" fertility in a reasonable distribution of reasonable decreases. Hence we have said in Chapter VIII that in colonial days second, third, and fourth births must have been physiologically possible in a distribution represented by a curve at least as high as the top curve $a^1 b^2 b^3 b^4$, on Figure 3. What once occurred can occur again today *if* parents should so desire. That is, it is physiologically possible for 1,602,001 women becoming mothers annually at present to produce 1,602,001 children a year without any of them being fifth births or of any subsequent orders.

TABLE VIII

WHITE BIRTHS IN U. S. REGISTRATION AREA IN 1925 BY ORDER OF BIRTH

Compared with Hypothetical Distribution of Twice As Many Births Among Same Number of Mothers. (Source of Col. 1, U-2)

Order of Birth	Number of Births	
	Actual in 1925 (1)	Hypothetical Distribution (2)
Total births	1,602,001	3,204,002
First	470,804	470,804
Second	354,054	414,054
Third	243,692	376,299
Fourth	160,844	340,844
Fifth	110,713	307,153
Sixth	80,011	276,084
Seventh	58,028	248,476
Eighth	41,873	223,629
Ninth	28,763	200,855
Tenth	19,417	154,734
Eleventh	11,837	90,000
Twelfth	7,208	50,000
Thirteenth	3,958	25,500
Fourteenth	2,020	12,800
Fifteenth	996	6,400
Sixteenth	511	3,200
Seventeenth	242	1,600
Eighteenth	122	800
Nineteenth	48	400
Twentieth	28	200
Twenty-first	12	100
Twenty-second	10	50
Twenty-third	2	12
Twenty-fourth	3	6
Twenty-fifth	1	2

APPENDIX C

ADDITIONAL CENTERS FOR BIRTH CONTROL ADVICE

The seventy centers for which details are given in Table I operate in about forty cities. Besides these the following centers have been reported, some in detail, but received too late for analysis, others by name or locality only. It is hoped that this list may be kept up to date, year by year, with as much detail as is possible. No attempt is made here to evaluate the items, which are listed in rough geographical order, following the sequence of Table I.

GERMANY

For information address:

Dr. phil. Helene Stöcker, Bund für Mütterschutz, Berlin-Nikolassee
Dr. med. Martha Ruben-Wolf, Berlin-Niederschöneweide, Berlinerstrasse, 129, 11 Tr.

Marriage Advice Stations. Sixteen such centers are listed in Table I. It is probable that all the 144 marriage advice stations reported by Dr. Niesser-Schroeter (N-4, first edition of 1928 immediately replaced) though they may not wish to be known as birth control centers are yet inclining to refer applicants with a demonstrated need on medical grounds. Dr. Cooper seems to be of the impression that about fifty-nine of these will prescribe for economic reasons as well.

Sickness Insurance. We have the assurance of Dr. Martha Ruben-Wolf that the public Sickness Insurance offices in Berlin, located as follows, prescribe for all who ask:

Lichtenberg, Parkaue, 14 a
Neukölln, Schoenstedstrasse, 13
Norden, Wildenowstrasse, 5
Schöneberg, Grunewaldstrasse, 30
Spandau, Pottsdamer Strasse, 48
Norden, Utrechter Strasse, 33

Other German centers reported are:

Breslau, Neue Taschen Strasse, 25 (Dr. Neufeld)
Darmstadt, Office of City Physician (B-4)

Frankfurt a M., Neue Krame, 7 (B-4)
Hamburg: Die Freunde des Rechtsanskunftswesens und Gütverfahrens (N-4, p. 18)
Hannover, Nickolaistrasse, 7 (B-4)
München, Universität Polyklinik

AUSTRIA

For information address:

Herr Johann Ferch und Frau Ferch, Frauenschutzberatungsstelle, Vienna, Königseegasse, 10, Tür 2

Herr Ferch and his wife have had five provincial centers outside Vienna. Karl Kautzky, son of the great social-economist, and Dr. Novak have organized centers in Vienna.

The centers numbered 22 and 23 in Table I have been discontinued, and new centers opened in Sickness Insurance offices at Goldschlagstrasse 193 and at Karl-Meistl-Strasse 5.

HUNGARY

Madame Rosika Schwimmer had a center at Budapest for a long while. (P-15, p. 114)

RUSSIA

For information address:

Dr. med. A. B. Genss, Department for Protection of Maternity and Infancy, Peoples Commissary for Health U. S. S. R., Moscow, Russia

All Russian gynecological and obstetrical clinics and maternal and infant health stations prescribe contraceptive care, which in its clinical and laboratory aspects is being studied most seriously by the Soviet government. (F-5, p. 337)

NORWAY, SWEDEN AND DENMARK

For information address:

Dr. Thora Mohr, Oslo, Norway

The Scandinavian countries have hardly had to have a special campaign for birth control, as the idea was readily assimilated by the liberal

thinkers, and leaders in medicine here generally included contraception in gynecological clinics. According to Dr. R. L. Dickinson, the following individual physicians have been most active in providing this service:

Professor Brandt of Oslo, Norway
Professor Essen-Möller of Lund, Sweden
Professor Gammeltopf of Copenhagen, Denmark

Other references are:

Dr. Alma Sundquist, of Stockholm, Sweden (S-19)
Dr. Thora Mohr and her physician husband are members of a league which has opened Mothers' Hygiene offices at Oslo and Stavangar, Norway. (B-24)
Bureau of Parents, Stockholm, Sweden (B-24)
Bureau for Parents, Gothenberg, Sweden (B-24)

THE NETHERLANDS

For information address:

Nieuw-Malthusiaansche Bond, Aelbrechtskade, 58 C, Rotterdam

There are no regularly constituted clinics in the Netherlands (P-7) but a national organization, the Neo-Malthusian League founded in 1881, has instituted a widespread and quite informal service, whereby women may receive instruction in a six lesson course given by doctors and midwives and thereafter set up centers among their neighbors. Fifty such centers are reported. This work is generally carried on by workmen's wives and four doctors and four midwives conduct the classes. A well planned circular is issued in simple language. The League of course carries on active propaganda and the Queen's name is used to sponsor it, as one among numerous charitable enterprises, but she could not if she would, be personally interested as the government has been Conservative for some years and one third of her subjects are Catholic.

BRITISH ISLES

For information address:

The Birth Control Investigation Committee, 41 b Clanricarde Gardens, London, W2
The Society for the Provision of Birth Control Clinics, 153 a, East Street, Walworth Road, London, S. E., 17

This society is starting clinics all over England as fast as possible. In addition to the ten listed in Table I, they give two new ones in their 1929 report:

Rotherham Mothers' Clinic, 58 Albion Road (Rotherham Mining District)
Newcastle Women's Welfare Centre, 670 Scotswold Road, Newcastle-on-Tyne

and announce a clinic at

Exeter, to be opened January, 1930.

Other English clinics are:

Brighton (B-23)
Cannock (a mining district) (H-3)
Cromer Welfare Centre, 57 Cromer St. London, W.C. 12 (Dr. Norman Haire, Director) (H-1)
Hednesford (a mining center) (S-14)
Plaistow Mothers Welfare Clinic, 476 a Green Street, London, E. 13
Southampton, (B-23)
Traveling Caravan of Dr. Stopes (S-18)
St. Thomas' Hospital, London (contraceptive service provided in gynecological clinic). We have had a personal report from editor of a leading medical journal, concerning interest of Dr. J. S. Fairbairn, Examiner in midwifery and Diseases of Women, University of London. See article by Fairbairn in which he makes it plain that he disapproves of birth control for self indulgent women. (P-13)
University of Belfast Hospital (according to Dr. Dickinson)
Abertillery and District Hospital, Wales

UNITED STATES

For general information address:

American Birth Control League, 152 Madison Ave., New York City, N. Y.

For medical and scientific details address:

Committee on Maternal Health, 2 East 103rd Street, New York City, N. Y.

New York. Beth Israel Hospital, Stuyvesant Square East, N. Y. C. (Service announced in gynecology department in fall of 1927, but never begun owing to building and administrative changes. They wish to be retained as they hope to establish a regular clinic under the auspices of the Committee on Maternal Health. In the meantime individual cases are advised as necessary.)

Three other organizations in the city report that they give advice when required, though without any special records:

Long Island Medical College Hospital, Brooklyn, N. Y.
Post Graduate Hospital, 21st St. and Second Ave.
Union Health Center, 131 East 17th St., N. Y. C.

Valhalla, N. Y., Grasslands, Westchester County Hospital (Clinic opened in fall of 1929, in obstetrics department, serving a large rural area).

A branch service for negroes was opened by the Birth Control Clinical Research Bureau, 1930, 2352 Seventh Avenue, N. Y. C.

Pennsylvania. For information, address Pennsylvania Birth Control Committee, 1700 Walnut St., Phila.

In spite of prohibiting laws a determined effort has been made to provide birth control service and this has been started under propitious medical leadership in the following places and upon advice that the obstructing laws are unconstitutional.

(Philadelphia) Maternal Health Clinic, Near 69th St. Terminal, Delaware County. This clinic receives patients only for health reasons and only on appointment. Telephone Blvd. 1726, Tuesdays and Thursdays between 2 and 4.

Reading. Address Mrs. Mary B. Nelson, or the Chairman, Mrs. Stanley Bright.

Scranton and Wilkesbarre have less formal provisions, service being offered by individual physicians through a league.

Virginia. The University of Virginia Hospital (University, Va.) offers incidental service in its gynecological department.

Minnesota. University Hospital Dispensary, Minneapolis, Minn. Pressing cases advised, in gynecological clinic.

NEAR AND FAR EAST

Cairo, Egypt. According to a report by the Y. M. C. A. a service was started by a physician in 1929, to take patients on references.

Hadassah Medical Organization. The Zionist group in Palestine has included provision for family limitation for medical reasons as part of its public health plan for the new settlers.

China. The Chinese Nationalists are reported to be interested in securing birth control advice for the masses. (H-9)

Japan. In Tokio there are some sixty small clinics, run on commercial basis. The Japanese law makes no prohibitions but also gives no encouragement to the work, according to a letter from Dr. R. B. Teusler, Director of St. Luke's American Hospital for International Service (Dec. 17, 1929). The Assistant Mayor of Tokio, Mr. Shirakami, and several others, including the Baroness Shidzue Ishimoto, are undertaking an active campaign to secure support and aggressive action by the government.

India. At Sholapur, Dr. A. P. Pillay has inaugurated a Wives Clinic in connection with the Maternity Homes, where birth control advice is given, especially to the very young wives under eighteen.

Also, address Prof. P. D. Shastri, Presidency College, Calcutta; and Prof. Phadke, Bombay. (P-5)

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